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MOTHER AND CHILD

A MAGAZINE CONCERNED WITH THEIR HEALTH

Vol. 2 No. 1

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JANUARY 1921

PUBLISHED BY

THE AMERICAN CHILD HYGIENE ASSOCIATION

BALTIMORE

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THE AMERICAN CHILD HYGIENE ASSOCIATION is engaged in maternal, infant and child hygiene work. Over 200 organizations are identified with the Association. The total membership of individuals and organizations is 2,200. The Association works with the men and women in each community who are taking the lead in public health and social betterment.

Membership Dues

Active members	$ 5 annually
Affiliated societies	5 annually
Contributing members	10 annually
Sustaining members	25 annually
Life members	200

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All classes of members are entitled to receive the Transactions, the magazine, and other publications.

The Association publishes MOTHER AND CHILD, a Magazine Concerned with their Health, which seeks to arouse the nation to a realizing sense of the present preventable loss of life of mothers and children.

THE TRANSACTIONS OF THE ELEVENTH ANNUAL MEETING OF THE AMERICAN CHILD HYGIENE ASSOCIATION

(Held in St. Louis, Missouri, October 11–13, 1920)

Papers, discussion and reports on the following subjects:

Pre-natal and Maternal Care
Expectant Mothers in Rural Communities; The Unmarried Mother; Inter-relation between Work of Obstetricians and Pediatricians.

Infant Care—Joint Session with Central States Pediatric Society.
Tuberculosis in Infancy; Conduct of Rural Infant Welfare Clinics by Public Health Nurses.

Infant Mortality and its Prevention
Effect of Infant Mortality on the After-Life-Time of Survivors; Infant Mortality and its Reduction in New Zealand; Studies in Infant Mortality Statistics.

Pre-school Age
Problems of Early Dental Defects; The Mental Health of the Child; Standards and Methods for Health Work among Children of Pre-School Age.

School Age and Adolescence
Publicity Methods in Health Education; Heart Disease in School Children; Economy of Preventive Measures in the Nutrition of School Children.

Reports of Affiliated Societies

Round Table Conferences
For Divisions of Child Hygiene, Rural Health Problems, Nursing and Social Work.

The Transactions are sent free to members, on request.

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American Child Hygiene Association

FORMERLY

American Association for Study and Prevention of Infant Mortality

1211 Cathedral Street, Baltimore, Maryland.

MOTHER AND CHILD

A Magazine Concerned With Their Health

Published Each Month by

The American Child Hygiene Association

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A Thought for the New Year

JOHN GALSWORTHY entreats us not to "drag the hands of the world's clock backward" by our neglect of the health of mothers and babies. He says:

"How do things stand? Each year in this country about 100,000 babies die before they have come into the world; and out of the 800,000 born, about 90,000 die. Many mothers become permanently damaged in health by evil birth conditions. Many children grow up mentally or physically defective. One in four of the children in our elementary schools are not in a condition to benefit properly by their schooling. What sublime waste! Ten in a hundred of them suffer from malnutrition; thirty in the hundred have defective eyes; eighty in the hundred need dental treatment; twenty odd in the hundred have enlarged tonsils or adenoids. Many, perhaps most, of these deaths and defects are due to the avoidable ignorance, ill-health, mitigable poverty, and other handicaps which dog poor mothers before and after a baby's birth. One doesn't know which to pity most—the mother or the babies. Fortunately to help the one is to help the other. * * * *

"There are many districts all over the country where there are no centers to come to; no help and instructions to be got, however desperately wanted. Verily this land of ours still goes like Rachel mourning for her children. Disease, hunger, deformity, and death still hound our babes, and most of the hounding is avoidable. We must and shall revolt against the evil lot, which preventable ignorance, ill health, and poverty bring on hundreds of thousands of children.

"It is time we had more pride. What right have we to the word 'civilized' till we give mothers and children a proper chance? This is but the Alpha of decency, the first step of progress.

"Into the twilight of the world are launched each year these myriads of tiny ships. Under a sky of cloud and stars they grope out to the great waters and the great winds—little sloops of life, on whose voyaging the future hangs, they go forth blind, feeling their way. Mothers, and you who will be mothers, and you who have missed motherhood, give them their chance."

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MOTHER AND CHILD

A Magazine Concerned With Their Health

VOL. 2 JANUARY, 1921 No. 1

Selling Health

Sally Lucas Jean*

Child Health Organization of America

WE have all heard much in the last few years of "Selling Health," but most of us have only a vague idea as to the meaning of the term or as to how health is to be sold.

There are two methods of reaching our public—through the spoken word and through print. The former method must necessarily be limited, first, because there are comparatively few individuals who can get their message "across," and second, because those who can are so in demand that only the large important groups can secure their time. Printed matter must be the medium upon which we depend.

How much the words "printed matter" bring to mind bulletins, reports, leaflets, magazines, posters. Most of us recall endeavors to make such material of interest, and even remember reading some of them when nothing of greater interest was at hand. We can recall going through page upon page of "good stuff" that was most difficult to read—sometimes that of our friends and sometimes our own. We have not made a success in public health literature, we will all admit, I think, and why?

PAPERS AND THE PRINTER

Our custom has been to call upon the man or woman who has dug out a new idea to write a paper on that subject, depending upon the printer to put it into readable shape. If the person is sufficiently well known, you can be sure of a broad circulation, but we are not sure of a reading public. As the crude old saying goes "You can lead a horse to water, but you can't make him drink." The prominent name will make professional people buy an article or subscribe to a magazine, but it does not secure assimilation of the facts contained therein. There is a technique in the presentation of facts which has not been included in the

*Paper read at the Eleventh Annual Meeting of the American Child Hygiene Association, St. Louis, October 12, 1920.

usual college course, and we must secure this assistance if we are to produce printed matter at the least expense to reach the greatest number. Most public health groups cannot afford the full-time services of a professional advertiser, but it is usually possible to get such advice for a special need.

PROFESSIONAL ADVERTISING ADVICE

My only role in discussing this subject, is that of an amateur who has been somewhat successful in producing readable literature with the assistance of a commercial advertiser. When a group of doctors from the Pediatric Section of the New York Academy of Medicine about two and a half years ago decided to form a general committee for the purpose of raising the health standard of the school child, the president of one of the leading advertising firms in New York was consulted, as to the name to be adopted, forms for stationery, and so forth.

A nominal amount was paid the first few months for his time, but since then he has been elected a member of the Executive Committee and gives of his time and that of his staff as needed. The "Child Health Organization of America" was accepted as a name with his approval, and practically all of the publications printed through our office, or reprinted in the Government Printing Office through the United States Bureau of Education, passed through his hands.

A PHENOMENAL SALE

The sale of this material has been phenomenal—2,600,000 copies of one book having been sold in less than two years—without the assistance of an agent. The Department of Documents reports a greater sale, with possibly one exception, of one of these publications in a given time than has ever been known in the history of the Department.

While consulting with a Southern University staff lately, I was asked for suggestions to improve their bulletins, and was told, "of course, we haven't anyone here to assist in their layout as you have in New York." I agreed to think over their problems and criticize their bulletin. On the train returning, I met a gentleman who proved to be the head of an advertising firm, living in a town quite near the university visited. This man said he had always been eager to improve those bulletins, but he did not suppose his suggestions would be welcome. It was not difficult to make the contact and you may be sure we shall see a greater readability in the reports of that university.

A FEW FUNDAMENTALS

There are several points which we can all observe:

Be sure of your facts. Reduce them to their simplest form.

Insist on good printing, and large enough type, well leaded, to be read easily.

Use good paper—wide margins,

and dull finished paper are especially desirable.

Short paragraphs are best. Make them subtle and suggestive—leave something to the imagination of the reader.

If illustrations are not possible, use large initials.

POSTERS

I know very little of successful posters, as mine have usually been failures, and are hidden away in the storeroom; but through our mistakes and those of our friends, we have learned that the poster must attract attention, make an instinctive appeal, be designed by a poster artist if possible, and carry only one message. Change the poster frequently. Think over the posters

This health poster was made by a Brooklyn high-school boy in a city-wide contest initiated by the Brooklyn Bureau of Charities and the National Tuberculosis Association. A splendid example of effectual simplicity

you remember. Close your eyes and see which ones come to you first. Most of us remember the "watch him register" which was one of the large signs carried lately, and the "toasted tobacco" sign. Why? One appeals to the curiosity, and the other to the senses of taste and smell—we all like the idea of toasted tobacco—that "instinctive appeal."

A poster came to us the other day, published by one of the most important groups in America with plenty of money at their disposal. A photograph had been enlarged, the name of the organization printed in big letters at the top and the subject to which they wished to call attention printed in small book type, one sentence containing about ninety-five words. Highly glazed paper had been used, which is not inexpensive. That group will wonder why their poster is not in demand.

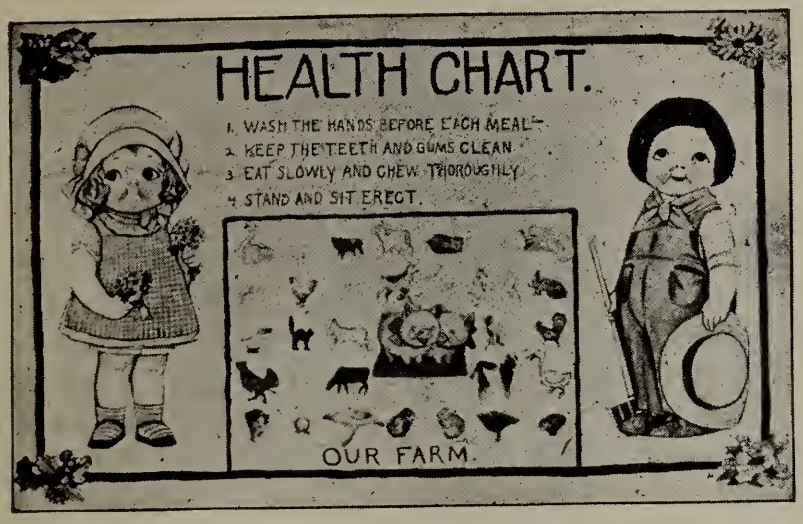
Many helps in poster making and kindred subjects will be found in the "A. B. C. of Exhibit Planning," written by the Routzahns and published by the Russel Sage Foundation. Harry L. Hollingsworth, Associate Professor of Psychology in Columbia University, has written a most stimulating book, "Advertising and Selling," which is a psychological study of the subject. This can be procured through Appleton and Company.

Again good posters are produced and shown in such masses that the onlooker is confused. A few posters changed frequently are of great value, but they are best used to stimulate the interest of local talent. The competition among children or local artists will have much more value. This is almost an untouched field but has proven to have great possibilities as developed.

A western city group offered prizes last year to the school presenting the best posters and compositions on "how boys and girls grow big and strong." The results were beyond all expectations. The children from the Kindergarten to the Eighth Grade showed that originality and imagination which we so seldom get from our Health Departments.

MOTION PICTURES ON HEALTH

Devices with action, colored lights, and so forth, are of value, though expensive. Motion pictures will, without doubt, be developed and used extensively; but we have few today that are noteworthy. Not until organized health groups realize that this is a commercial field and must be entered with the assistance of motion picture experts, can we hope for successful pictures. Making a picture means a large expenditure of money and time—much time of an imaginative person with health knowledge working with the motion picture expert. When we learn to handle this tool in this way, we shall make it profitable to the cause of health education, and it will pay for itself in a few months.


HEALTH CHART.
1. WASH THE HANDS BEFORE EACH MEAL.
2. KEEP THE TEETH AND GUMS CLEAN.
3. EAT SLOWLY AND CHEW THOROUGHLY.
4. STAND AND SIT ERECT.
OUR FARM.

Designed by a student of the Trenton, New Jersey, Normal School. Too much detail makes an ineffectual poster.

NEWSPAPER AND OTHER PUBLICITY

Before closing, I want to suggest that every State health group, at least, have a clearing house for child health literature, so that workers in the most remote parts of the field may call upon such a central body for assistance in preparing articles for the ever important local papers as well as for the more intimate group. The State body should use the best ideas developed by the National groups, the National bodies in turn profiting from clever developments in the States. Not until some such plan is developed are we going to reach our public with a minimum amount of effort.

It has been said that our infant death rate depends upon the amount of money we are willing to spend. May I add that the health of our boys and girls depends upon the amount of imagination we are willing to expend.

We have talked and taught health laws and the results of breaking these laws and have not succeeded in making a dent upon the habits of our young people. A circus clown can be a more effective teacher for boys and girls than the most learned scientist. The clown can interpret the laboratory to children in their own language and so establish health habits before these boys and girls are old enough to understand mature presentation. I see the day not far off when the health experts will find it quite worth while to sit with school authorities in developing plans for the actual teaching of health in the elementary schools; not just to work out methods of discovering and correcting defects, but plans for interesting each child from the kindergarten to the college in the practice of health habits. With such a co-ordination, we may expect to build strong boys and girls fit to live life fully.

Heart Disease in School Children

Charles Hendee Smith, M. D.*

Attending Physician Children's Medical Division, Bellevue Hospital, New York City

DURING the past few years there has been a gradually awakening consciousness to the fact that the cardiac problem has been too long put aside. The time has come when it must be recognized as a large problem and one which deserves a completely organized program of the type which has been developed for tuberculosis, the care of infants, and so forth.

The large incidence of heart disease is unquestioned. Organic heart disease competes with tuberculosis and pneumonia for first place among the causes of death. It is true that death takes place in adult life, but the heart disease is commonly acquired during the school age. The number of cases of heart disease which are discovered in school surveys varies considerably, but every school survey detects a certain number of children with cardiac lesions. The estimates of the cases among school children in New York City give from one and a half to two per cent, that is from 18,000 to 25,000 children. Our hospital wards are crowded with cardiac cases and they make up a large proportion of the children applying for treatment in out-patient departments. The draft, industrial and insurance examinations have all given the same result, i. e., about two per cent of the men examined have been found to have heart disease. This means more than 2,000,000 cardiacs in the United States, since the incidence in women is even greater than in men.

NEW YORK'S TWENTY THOUSAND

What will be the ultimate fate of the 20,000 children in New York with heart disease? The hearts of a certain number of them are hopelessly damaged and the children are doomed from the start. They die after a few months or years of acute suffering. The large majority of them, however, are not struck down permanently, but after warding off the first onslaught of their disease, live on with or without symptoms for a number of years. It has been said that it is not worth while to educate cardiac children, that they all die in early adult life and that money spent upon them is a waste of public funds. This view is not justifiable, for it is not borne out by the facts. Most of these children do grow up; a great many of them under proper care can be made to lead comfortable lives and become useful citizens. A certain number, perhaps not large,

*Read at the Eleventh Annual Meeting of the American Child Hygiene Association, St. Louis, October 12, 1920.

actually outgrow their heart disease, and have left neither symptoms nor physical signs. Others make a functional recovery even though the murmur persists. A very considerable number of children who have gone through acute decompensations can be made to so far recover as to go on through school and take up a not too strenuous occupation. There is in addition a larger number of children who have definite cardiac lesions who can be kept so well and strong by care and supervision that they never approach the stage of decompensation. It is for these last groups of children that we must have a definite program laid down which will do more for them than has been done in the past.

PREVENTION

In mapping out a program for the care of the cardiac child, the first thought is prevention. Here lies the greatest difficulty at present, but here is the most fertile field. We all believe, and it has been demonstrated with fair certainty, that the portals of entry for rheumatism and other diseases which affect the heart are diseased throats and carious teeth. Statistics are lacking at present to accurately demonstrate that wholesale removal of tonsils, and perfect care of the teeth would diminish the incidence of rheumatism, but it is impossible to avoid the feeling that this would probably be the case. St. Lawrence has recently demonstrated that a series of eighty-five children had fewer sore throats, joint pains, attacks of chorea after a complete tonsillectomy than before. The facilities in New York, and in most cities, for the care of throats and the teeth are ludicrously inadequate, and until they are multiplied many fold we shall have no accurate figures to prove that this is true for large numbers. The time must come, however, when the cities and states awaken to the fact that these measures of preventive medicine would give an enormous return for money invested by the prevention of illness and of crippling by disease.

Besides the removal of the portals of entry another preventive measure is the better care of children suffering from the infectious diseases which affect the heart. Rheumatism must be diagnosed earlier, children with it must be given greater care, kept in bed longer than in the past. Chorea must be regarded as a grave disease and not merely treated with tonics, fresh air and exercise. These children all deserve bed treatment and after their acute attack should have their tonsils removed and their teeth given the utmost care. The occurrence of two or three cases of rheumatic infection in one family which we see from time to time makes it probable that we should keep the rheumatic child away from other children during his illness and for some time afterwards.

DIAGNOSIS AND CLASSIFICATION

If anything is to be done for the cardiac child, the diagnosis must be made as early as possible and he must be given every opportunity to escape the disastrous consequences of neglect. This means more thorough and more frequent examinations of every school child. School examinations have done a great deal in raising the level of school child health, it is true; but until they are improved in quality and frequency they will fall short of their maximum usefulness. The school physician at present must examine too many children too hastily to detect every cardiac case. In some cities he is not allowed to remove the clothing from the child's chest, with the inevitable result that many mistakes are made. The teachers can, of course, pick out the children with shortness of breath and evident cardiac weakness and set them aside for special examination, but it should not be necessary to wait until this late stage to make the diagnosis. Unfortunately, the school physician is not always properly trained in recognizing heart disease. It is a common experience in New York City to have children referred to hospitals as cardiac cases who fail to reveal any sign or symptom of heart involvement upon the most careful examination. It is probable that at least as many mistakes are made in the other direction and that much actual cardiac disease escapes detection.

The diagnosis and classification of cases having abnormal physical signs in the heart has been far from satisfactory. Various attempts have been made to classify children on a functional basis so that it could be made clear to doctors, nurses and teachers as to how great is the functional disability, and how much work each child should be allowed to do. The classification adopted by the Associated Cardiac Clinics is in general use in New York at present, and while not entirely satisfactory has been a step in the right direction. It is as follows:

Class I. Patients with organic heart disease who have **never had symptoms** of cardiac insufficiency under ordinary conditions of activity.

Class II. Patients with organic heart disease who have had such **symptoms in the past,** but who do not have them at present under ordinary conditions of activity.

Class III. Patients with organic heart disease who **at the time of observation have symptoms** of cardiac insufficiency following ordinary exertion.

Class IV. Patients with **possible heart disease.** Patients who have abnormal physical signs in the heart, but in whom the general picture of the character of the physical sign leads us to believe that it does not originate from cardiac disease. ("Functional" murmurs, arrhythmias.)

Class V. Patients with **potential heart disease.** Patients who do not have any suggestion of cardiac disease, but who are suf-

fering from any infectious condition which may be accompanied by such disease; or who have suffered from such diseases; e. g., rheumatic fever, tonsilitis, chorea, scarlet fever, syphilis, and so forth.

It is recommended that this classification be used as a part of the diagnosis of each patient; e. g., Chronic Cardiac Valvular Disease, Mitral Stenosis and Insufficiency. Class II. The potential group is included because it is upon these that the most important preventive work can be done. This classification at least serves the purpose of making clear in the mind of the nurse, the social worker, teacher, and convalescent home, the fact that the children under observation in a cardiac class do not all have serious organic heart disease, and that only the Class III cases really need restriction of their physical exercise. In the early days of the cardiac classes it was a very common experience to find a child with a functional murmur who had been warned not to run, nor walk up stairs, to say nothing of the injunctions against "red meats" and even "acid fruits." When this classification was made it was felt that all children who showed any symptoms whatever due to the heart should be given extraordinary care, and that there are so many degrees of symptoms that differentiation into sub classes would be difficult or impossible. After trying this classification for three years it is evident that there would be some advantage in having Class III further sub-divided into cases with mild and severe symptoms; or into cases which have at some time actually decompensated, and those which have never had a real break.

OBSERVATION

After the diagnosis of heart disease has been made upon a child, he should be under continuous medical observation. There is no other disease for which this is so absolutely essential. The child must therefore be under the care of a private physician, or else some means must be devised for providing this observation by clinics. In the past, the treatment of cardiacs in Out-Patient Departments has been casual, unorganized and unsystematic.

The class method of treating patients with tuberculosis, malnutrition, and so forth, has proved definitely that this is the only way of handling large numbers. The saving of time of doctors, social workers and nurses, is alone enough to justify this plan. The class idea for the treatment of cardiacs has only come forward in recent years. Lucas had a cardiac class for children in Boston in 1912. Guile started a cardiac class for adults at Bellevue in 1911. Ferguson began the group study of cardiac children at Bellevue soon after. In 1916, a class for children was started by St. Lawrence in St. Luke's Hospital. At about this time a group of physicians conceived the

idea that the cardiac movement was large enough to warrant the formation of the Association for the Prevention and Relief of Heart Disease. Largely under the stimulation of this Society, cardiac clinics were started in numerous other institutions, and in 1917 the Associated Cardiac Clinics were organized with a membership of fifteen or twenty. Today there are thirty cardiac classes for adults or children in New York City, with over 3,000 cases under observation. Meetings of the Associated Clinics are held three or four times a year and public meetings of the parent Association two or three times a year. At these meetings most interesting papers and discussions have been presented, and the procedure in the cardiac classes has been standardized to a considerable extent. The cardiac classes have been developed in many institutions to a state of very high efficiency. Most of them have full time social workers.

A CARDIAC CLASS

The class in which I am especially interested is that supported by the John Huddleston Memorial Fund at Bellevue Hospital. This foundation was established in the fall of 1916, in memory of Doctor Huddleston, who was contemplating this work at the time of his death. It made possible the reorganization of the cardiac class which had been in existence for two or three years. Over 500 children have been studied; about 360 were under observation last year, including

Organic heart disease, acquired	135 cases
Organic heart disease, Congenital	20 cases
Possible	120 cases
Potential	83 cases

In conducting this class, four general principles are kept constantly in mind; first, diagnosis and classification of cases; second, the care of the cardiac condition itself; third, the care of the child's health and nutrition; fourth, the removal of portals of entry (care of the teeth and tonsils).

After the diagnosis and classification have been made, it is necessary to decide just how much attention need be paid to the heart. Children with decompensation or with severe symptoms on slight exertion require bed care. The hospital is the best place for this, except in the case of a very nervous child, whose home conditions are such that proper care can be given. This requires an unusually intelligent mother, and frequent visits by the clinic nurse or doctor. Excellent results can be obtained at home under proper supervision.

THE QUESTION OF EXERCISE

A great many children with heart disease require little restriction of their exercise. They can run and play and lead normal lives. This is true also of practically all of the "possible" ("functional") cases. The majority of the children with organic disease lie between the severe and the very mild cases. The exercise which each child may take,

A CLASS FOR CARDIAC CHILDREN

The waiting children and mothers watch the doctor and hear the advice he gives on the care of the teeth, exercise, feeding, and general hygiene.

The food exhibit shows three average meals which should be given each child.

and the amount of rest he needs must be decided for each individual case, and must be definitely prescribed. Written directions should be given for the daily routine and for the amount of rest and activity advised. Most of these children are able to be up and about—and can walk easily—but few should run far or climb stairs rapidly. Children who have lesions of a degree to give symptoms on exertion, are urged to stop after each flight to rest until they breathe normally, not to run, not to play violent games. It is difficult to control the amount of exercise taken, for such children naturally want to do all that their playmates do. Those with little cardiac reserve soon learn how much they can do without discomfort. It is certain that too much restriction has been put upon many children in the past. Nearly all our children attend school, climb stairs and even run a little with no ill effects.

We have found no simple and easily applied functional test for cardiac efficiency. How to measure the exercise tolerance is at present one of the greatest needs. We have tried various tests, the change of pulse rate after exercise, change of pulse and blood pressure on change of posture, and Barringer's delayed maximum rise in blood pressure. All of these give useful information at times, but occasionally are misleading. The rate and size of the heart, the character of the apex impulse, and the general aspect of the child before and after mild exercise, give a fairly good

impression upon which advice may be given.

IMPROVEMENT OF NUTRITION

The third object of the class is to improve the general nutrition of the children. It is believed that this is the best means in our possession to combat the problem of heart disease. It may not be desirable for adult cardiac patients to put on too much weight. A growing child offers a different problem, however, for his heart grows with his body. It is only by improving his general nutrition that we can insure that the nutrition and growth of his heart muscle will be improved. It is an easily determined fact that many children with heart disease are undernourished. In the Huddleston clinic fifty-five to seventy-five per cent of the children are underweight for height and age on admission. It is a matter of common observation that improved heart action goes with a good gain in weight; also children whose hearts do badly rarely gain or grow normally.

The methods used in attempting to improve the nutrition are those already described in the reports of the Huddleston Class, as they have been developed in this class and in the Nutrition Class at Bellevue.* The regulation of the hygiene and diet of the child is the prime object, for if a child can be made to eat proper food and live a life correct in its hygienic details, he will be healthy and will gain and grow, provided he has not too serious an organic disease. The correction of the hygiene is no simple matter in a city like New York. Poverty, ignorance, poor food, bad racial habits of living, bad housing, crowding indoors and out, late hours, insufficient light and air, all contribute to the difficulty. Lack of co-operation from the parents may be due to failure to comprehend directions either through the lack of intelligence or on account of the bar of language. The habits of life of many of the children are at fault in almost every single detail, and must be corrected in so many ways that one scarcely knows where to begin, yet no results will be obtained unless these habits are all corrected.

Special verbal and printed instructions to each child and parent, and class talks to groups of children are the chief means of education available. The rivalry of class competition, weight charts, and prizes are used to stimulate children to try to gain. Constant repetition of the health lessons is required, for the children relapse into bad habits unless they are watched carefully. Home records kept by the children are useful in checking their habits. The application of all these methods gives results. The average gain of the children in the class is somewhat higher than the expected rate for the different ages. In other words,

* American Journal of the Diseases of Children, June, 1918, xv, 373.

heart disease does not prevent us from improving the nutrition of these children.

REMOVAL OF PORTALS OF ENTRY

The teeth of each child are inspected at every visit. We have a dentist in the next room who attends to the smallest cavity.

The question of tonsillectomy comes up in every cardiac. We believe that every child who has had a rheumatic infection should have his tonsils removed, provided he is in a condition to stand the operation. If his heart is not doing well, or if he is very much underweight, it is better to have him sent to the hospital, or even send him to a convalescent home for a few weeks before it. There is usually a loss of weight after the operation, and when a child is at low water mark, the shock and loss of weight often strike a blow from which he recovers with difficulty. We also keep every cardiac in bed in the hospital six to ten days after the operation. We have definitely shown* that this does much to lessen the loss of weight, and that the weight lost is regained much more quickly.

CONVALESCENT HOMES

When the nutrition cannot be improved at home, the children are sent to convalescent institutions. We have been most fortunate in having the Pelham Summer Home at our disposal, except for a few months in the winter of 1918-19.

Five years ago there were but one or two convalescent homes in the vicinity of New York City which were willing to accept cardiac patients. There existed in the minds of the managers of most of these homes a vague feeling that the child ill with heart disease might drop dead or that he was likely to become a bed patient and so was not a fit case for their care. The Burke Foundation, and the Campbell Cottages at White Plains and the Pelham Home were among the first to realize that this stand was not a proper one. These institutions have shown plainly that cardiac patients, if properly selected, can be given convalescent care with great benefit to themselves and without an undue burden upon the institution. Following their example, and under the stimulation of the Association for the Prevention and Relief of Heart Disease, a number of other homes have opened their doors to cardiacs, and several new institutions have been started for the express purpose of taking heart cases only.

The experiment of the Pelham Home has been under the immediate direction of the Huddleston Class and the experience there has brought out a number of facts of importance. The bed patient, the patient decompensated or in danger of decompensation should not be sent to an institution of this kind. These are hospital cases and should be kept in hospitals or in chronic

*New York State Medical Journal, May, 1919.

cardiac homes. The convalescent home is not as a rule equipped to take care of a large number of bed patients. The type of patient who does best in the convalescent home is the one who has a moderate heart lesion, and whose nutrition is impaired either as a result of the heart disease or of any other cause. Cases must be selected with care. It is absurd to send away a fat rosy child with a functional murmur, who happens to be a pet of the doctor or social worker. No children should be sent with acute joint symptoms, nor for two or three weeks after these symptoms have subsided, nor with acute chorea, since these may do badly and need separate hospital care. The teeth must be put in order, and the tonsils removed if the patient is fit for the operation. There must be no pediculi, vaginitis, open tuberculosis, or other contagious disease. The mental qualities of the child must be considered, for it is unwise to send away mental defectives, degenerates or even badly spoiled or very nervous children who rarely profit by leaving home.

It has been found that it is best to keep the children at Pelham Home for as long a time as possible. It can be decided as a rule in a week or two whether the child is likely to do well under existing conditions at Pelham. Homesickness, refusal to eat the food provided or recalcitrance to the rules show that certain children will not profit by a stay and they are sent home after a fair trial. The children who improve are kept for several weeks—even for two to six months. The routine in the home is simple. Reg-

CONVALESCENT CARE FOR CARDIAC CHILDREN

The milder cases can play quiet games for part of each day.

ular hours, wholesome and abundant food, a rest after lunch for all, short walks on a level road for the children who are fit to exercise, and rest all day on the veranda for the more severe cases. The children rarely gain in the first two weeks, but soon thereafter begin to gain rapidly. The improvement is often astounding. The rate of gain in weight in children who stay longer than a week or two (i. e., suitable cases) averages four times the expected rate for the different ages. The adolescent girls have gained at the average rate of forty pounds a year; girls under twelve at about twenty pounds a year.

After the return from convalescent homes, there comes a critical stage in the lives of these children. The return to their old home surroundings all too frequently means a return to unhygienic living. The weight gained in the hospital and convalescent homes may be lost in a few weeks. A small loss is not necessarily serious for there may be a little surplus fat—but unless care is taken, and unless every effort is made to continue the good habits of eating, resting, sleeping and so forth, the permanent improvement hoped for will not be attained. These children should report each week with their mothers, and every effort should be made to retain the weight gained which is one measure of improvement.

The connection between the convalescent home and the cardiac clinics has been kept closer by

CARDIAC CHILDREN REST IN A CONVALESCENT HOME

The more severe cases rest all day on a sunny porch.

special cards which have been provided by the Associated Cardiac Clinics. One-half is filled out by the clinic in referring the patient to the home. It gives the diagnosis, classification, amount of exercise advised, with the other necessary facts. The home is supposed to fill in the weight on admission and on discharge, co-operation, progress, length of stay, advice given on leaving, and to return the card to the clinic.

HOSPITAL CARE

In the past the cardiac has been kept in the hospital only for the shortest possible time. He has been discharged as soon as the urgency of his symptoms abated to such a degree that he has been able to get out of bed. Milder cases have been discharged as soon as the staff has made a diagnosis and be-

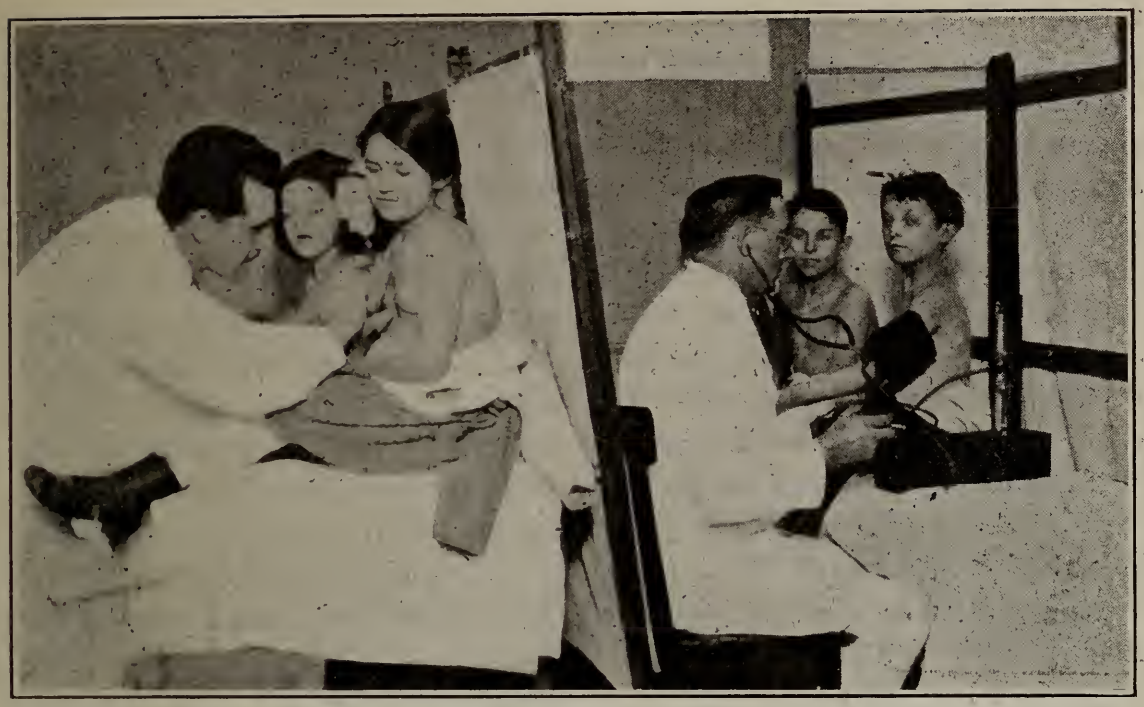
come tired of listening to the murmur. The result has been that the cardiac has been the most notorious of hospital repeaters. We have found that one long stay is much better than several short ones, and often keep the patients for many weeks, or even months. They are then discharged to a convalescent home if they are suitable cases, and thus the period of rest is prolonged so that the patient gets as far as possible away from his acute decompensation. The results under this plan are often astounding. The child who comes into the hospital on the verge of a severe decompensation, after a stay of one to three or four months, is sent to a convalescent home for three or four months more, and comes back so much improved in general appearance, color, nutrition, and above all, in heart action, as to be scarcely recognizable as the same child. Gains of fifteen, twenty, even thirty pounds are not uncommon.

CHRONIC CARDIAC HOMES

There is a group of children with badly damaged heart valves and muscles who are just able to be up and about part of the time, yet who are exhausted by very mild exertion. Coming to the clinic is about the maximum effort which they can stand, if they can do even this. Such cases are almost hopeless—and the main object with them has been to keep them happy. They are urged to rest a great deal, which indeed, they are forced to do by the severity of their lesions. They spend a good part of each year in the hospital or convalescent home, and are the cases which die of heart disease in a year or two. What they need is a chronic cardiac home, a haven of refuge in which they may be made happy and as comfortable as possible while they live. They are not fit cases for the regime of the average convalescent home for these homes are not equipped for bed patients. If we had chronic cardiac homes, the lives of these unhappy children might be prolonged and made fairly comfortable. Many of them live on for years and could be educated and taught light occupations which would keep them busy and perhaps even help in their support. This is a field which has not been opened up as yet. It is hoped that some of the institutions for convalescent cases can be induced to open cottages for chronically disabled children. They certainly deserve more care than they are given at present, for the hospital ward is the only place for them, and they cannot be kept in hospitals indefinitely. They are the most pathetic children in the world today, and their patience under suffering wrings deep sympathy from the hearts of everyone who comes in contact with them.

EDUCATION

The education of the cardiac child offers the greatest difficulty. The amount of absence from school of the children whose hearts' function has been impaired, is greater than that of any other group. The



PHYSICIANS EXAMINING CHILDREN OF A CARDIAC CLASS

The girl who is being examined has been in the heart clinic for almost four years. She had several attacks of decompensation, and was in the hospital, and in convalescent homes many times. At present she is plump and rosy and has no cardiac symptoms whatever. She has gained 24 pounds in 3½ years.

The two boys on the right have just been admitted to the class. Their hearts are acting badly, and they are undernourished and pale.

question of special school classes for them is one which is being tried out at present in several schools and institutions in New York. Each of these school classes is in close connection with a cardiac clinic. They have shown definitely that the children do very much better than in the regular school class and that absences are much reduced.

Opinion is not unanimous as to the necessity for these special classes in every school. Surveys of certain schools have shown a definite percentage of cardiac cases, but most of them with not enough impairment of function to prevent their attending a regular school class. There are, of course, many cardiacs who cannot climb stairs and who need a ground floor classroom, or one reached by an elevator. There are not enough of them in most schools to require a special class room. It is probable that there should be such a class room in every second or third school, that is one in each neighborhood which could be reached without too long a journey. The large majority of cardiac children can climb the one or two flights necessary to reach their school rooms. If necessary, special consideration can be given them by the teacher. They need not march in line with the other children, nor in fire drills, but should be allowed to go slowly upstairs and rest as much as they choose. A few children in our cardiac class climb stairs once a day, taking their lunch and coming down

at noon. Some children are given a longer noon hour. If a child is not able to climb one or two flights of stairs slowly each day, it is probable he is not fit to be in school at all, but should be in a hospital or convalescent home until his condition is improved. There should also be provision for teaching children in the hospital and convalescent homes because they are nearly all much retarded, and should not be allowed to lose more time. The Board of Education has also a few visiting teachers who go into the homes of the children who cannot come to school at all.

The education of the cardiac child of course must not stop with his ordinary school training. He must learn many things not in the books; he must learn in the first place that he has a handicap, that he has a weakness, and what he can do and what he cannot do with safety. There is a good deal of criticism of the cardiac clinics on the ground that the children become self-conscious, and feel that they are different from other children. This is all too true; the unfortunate cardiac child is different from other children and the sooner he learns it, and what he can do with safety the greater is his chance of living a life in comparative health and comfort. He must learn how much physical exercise he can take and beyond which he must not go. He need not be made a hypochondriac, however, and cardiac clinics can do much to dispell the gloom and hopelessness which is commonly instilled into the cardiac child by his anxious parents, friends, teachers, and even by his doctor. In addition to this lesson, he must learn the value of rest and of long hours of sleep, of fresh air and cleanliness, regular hours of eating and diet, and all the other laws of health. The average child pays a penalty for breaking any one of them. Their slightest infraction may spell disaster to the cardiac child.

The education of the parent is just as important, perhaps more important, than that of the child. Especial care must be taken to make very clear to these parents that their child is handicapped and requires unusual care, and that they can only keep him well, by helping him to learn his lessons of habit and hygiene; but that he must be saved from self-pity, and kept cheerful and hopeful.

The education of the physician in matters relating to heart disease has been far from adequate. It is not sufficient to teach medical students about murmurs and digitalis. They must learn that a cardiac patient is a child and must be treated like a child, not like a case with a heart murmur. The special cardiac clinics offer an unusual opportunity for medical students and graduates to become thoroughly familiar with the whole problem and with the various types of heart disease. Besides the instruction given the undergraduates and the internes in The Huddleston Class, we have graduate stu-

dents, many visiting physicians, social workers, nurses, undergraduate nurses and volunteer lay-workers, all of whom profit by the opportunity for observation of the material and the methods shown.

The education of the public, which includes the authorities of schools and hospitals, and the city and state governing bodies, must also be considered, for a program cannot be laid down nor carried out without co-operation and money. Public opinion has to be formed by much discussion before city fathers can be induced to make appropriations. The Association for the Prevention and Relief of Heart Disease* has made a small beginning in this direction. It is a small society as yet, and needs members and funds to enlarge its work. With a very small annual expenditure and the services of an executive secretary and stenographer, a great deal has been accomplished in New York and in other cities to some extent.

The formation of most of the thirty cardiac classes in New York has been largely due to the stimulation given by this Society. An office is maintained where all sorts of information pertinent to the subject is collected and made available for reference. Thousands of leaflets have been printed for distribution to doctors and patients. A survey has been recently made concerning the work in all the cardiac clinics and deficiencies have been pointed out in social service and other directions. The office acts as a clearing house for admitting patients to certain convalescent homes, which receive cardiac cases, largely due to its influence. New members will be very welcome, either individuals or institutions.

*325 East 57th Street, New York City.

VOCATIONAL TRAINING

At present the provision for vocational training of cardiacs is limited. It must be expanded so that each child can be taught a light or sedentary occupation which he can undertake with safety. It is probable that it would be better to spend most of our effort in arranging to have children enter existing occupations than to try to teach any new or any single occupation to a large number of cardiac children. A good deal of headway has been made in this direction in New York through the Bureau for the Employment of the Handicapped which places many cardiacs in light occupations every year. There is still a big gap to be filled, however, in the placing and supervision of children during their first working years.

The solution of the cardiac problem has been barely begun by the means described in this paper, and many aspects remain untouched.

There are many points of similarity between the tuberculosis and the cardiac problems. The analogy between the two is fairly close. Both are usually contracted in childhood or early adult life. Both

may lead to a rapidly fatal result, but commonly go on to a chronic stage with attacks of acute symptoms. Both incapacitate the patient for much or perhaps all of his former activities. Both are the cause of tremendous economic loss to the community and compete for first place in the list of causes of death.

What is the keynote of the whole program of the care of the tuberculosis patient? As soon as the diagnosis is made he is told that he must go away to a sanitorium and must stay there for three, six months, a year or even two years, in order to arrest his disease, and that he must lead a most careful life thereafter.

At the sanitorium he is taught what rest means; what to eat and drink, and wear, the importance of sleep, fresh air, cleanliness, and of regular bowel function. He learns just how much exercise he may take and what kind is best for him. He learns all the laws of hygiene and health, especially those which have a bearing on his particular disease. He is also advised as to his life after leaving the sanitorium; what kind of work he may do and how to take care of himself after going back to work.

In brief, the tuberculosis sanitorium gives two things, the cure, and education for future life.

Where does the cardiac patient get these things? There is no question but that he needs them both. The cure which he needs is but little different from that given the tuberculous. Rest and more rest, sleep, food, and fresh air, graduated exercise under medical supervision—practically the same essentials. He needs even more the education for life after graduation from the sanitorium, for a patient with an arrested tuberculosis may do many things which would mean disaster for the cardiac.

Would it not be better, then, to make some sort of sanitorium treatment for heart disease, the keystone of its care?

Early careful diagnosis would be an essential to this plan, and after this it should be possible to give the patient a chance, perhaps his only chance, to put himself in the best condition to handle his handicap for the rest of his life. In the past we have been compelled to wait until signs of failing heart muscle have given us an excuse to admit patients to hospital wards, or to be content with short periods in convalescent homes where the care still leaves much to be desired. If it were possible to send the cardiac patient at the very outset of his trouble to an institution built and conducted on the lines of our best tuberculosis sanitoria, with special adaptations to the differences of the two diseases, who can foresee the tremendous difference in the outcome which would result for the large majority of our heart cases?

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66 West 55th Street, New York City.

Volunteer Service in a Chicago Center.

Volunteer Service in Child Welfare

Sara B. Place, R. N.

Superintendent of the Infant Welfare Society of Chicago.

"THE Woman's Auxiliary!" When you hear it do you immediately picture a group of very busy women serving a church supper to "family" in the parlors of the home church—do you?

Not an euphemistic term—by any manner of means. A thousand times no in its application to the work of the Infant Welfare Society of Chicago. This story is of a Woman's Auxiliary serving some ten thousand mothers annually—mothers hungry for knowledge in mother craft and its immediate application in their homes, to their children. Because of the aid of the Woman's Auxiliary the employment of doctors, nurses and dietitians is made possible and they in turn directly serve Chicago mothers and babies.

The Infant Welfare Society of Chicago stands as an educational body in the field of Public Health, teaching each year some eight to ten thousand mothers the best way of keeping babies well. This is

accomplished through twenty-four stations to which mothers may bring their babies for conferences, getting advice from the doctors, and detailed home instruction from the nurse. Nine such stations carry nutrition clinics for the child up to six years of age, having the additional service of dietitians who help mothers solve the home problems. In three stations have been established pre-natal clinics where expert advice is given the expectant mother and follow up home supervision is given by the nurse.

HOW LAYWOMEN HELP

The Woman's Auxiliary of this organization came into being as a result of the inspiring reports concerning the work which the women of the Board carried back to their local groups. Interest was aroused and the isolated groups wanted to help. The way was pointed by turning over to a group of suburban women the financial support of a station. That they might be more convincing in their appeals for contributions, conferences were attended. Need you be told what happened? With the full knowledge of what such education meant to these foreign mothers, there was no need of further urging the volunteer. At once they saw dozens of ways whereby they could not only give of their money, but could give themselves in service at the station. This gospel of service was a most appealing one and spread to other groups until now almost every surrounding suburb has its Center in addition to the local Centers in the city.

Each Center elects its officers who constitute the Executive Committee which is the governing body of the Woman's Auxiliary. The President is an ex-officio member of the Infant Welfare Board and, inasmuch as all women contributors are members of the Auxiliary, its representation on the main Board is very substantial. Such committees as are necessary to carry out the program of the Auxiliary, work with like committees of the Society. Centers have such additional committees as best serve to carry out their local plans—either financial or for general service.

Just exactly what do the women of the Auxiliary do? First—they raise money. Last year (1919) the Woman's Auxiliary contributed sixty-three per cent of the total contributions of the Society. How do they get it? Each Center is a law unto itself in this respect and makes its financial plans. Some Centers have a house to house canvass—some membership drives—some community chests—and the newest venture—thrift shops. Thrift shops have been called "glorified rummage sales," and surely any thrift shop is worthy of glorification when it has served the community so unfailingly that a request is made to it for a fire escape. There had been a dearth of dwellings and the lack was being more and more keenly felt. A

woman who had trudged the South Side over, unearthed the loft of a building in which she would be permitted to reside, if a fire-escape could be provided. She turned in desperation to the thrift shop. The fire-escape was produced! Everything was sold. Everything from the wedding gift that would not fit in any place to Jane's outgrown clothes. Many a co-ed had a corking good time in the slippers that ruined the evening for Mr. and Mrs. Lumtum at the last Club formal.

Not any of the members of the Woman's Auxiliary were willing to visit stations week after week and not do something during conference time. Once the imagined terrors of the metric system were removed we had splendid volunteer help with the weighing of babies. Now in any number of stations, volunteers take entire charge of the weighing—being very punctual, very much interested. They have been known to stay straight through to the bitter end of weighing seventy babies. A heroic feat, anyone will admit. That is, anyone who has stood by and heard two or three babies simultaneously increasing chest expansion. Much may be added to the smoothness with which a conference runs by giving mothers help with the other children, with baby carriages, etc. This all makes for that orderliness which is essential and which does not need the attention of a trained person, who may thus be freed to do the piece of work which counts most for the mother and child.

BABY CLOTHES BOUGHT AND SOLD

Members of the Woman's Auxiliary make it possible for the most unfortunate mother to have a complete layette for her baby. Such simple layettes are made during meeting times and are sold to the mothers for a nominal sum, but given when in the opinion of the nurse that is necessary. Such joy as these dainty things bring to the mother's heart, often over-burdened with care!

Out of many requests from mothers for the purchasing of clothes for the older children came a now well established custom of holding clothes sales regularly. Outgrown children's clothing is collected from friends, carefully sorted and priced, and a clothes sale announced. Mothers learn of it at conference time and the nurse carries the glad tidings into the district. These sales are held at the stations, not at conference time, and the money procured goes back to the purchasing fund for material for layettes. Sound economies, surely.

"THE PURSUIT OF HAPPINESS"

Annually, at Christmas time, the Centers provide very happy times for the mothers whose babies are registered in their stations. The aim has been, not so much to give presents as it has been to get all the mothers together for a very merry time. The type of the community in-

dicates the nature of the festivities. Always a Christmas tree and simple toys for the children, with ice cream for the grownups, often a delightful program of folk songs and dances, and occasionally a marvelous combination.

The Legislative Committees of groups have been powerful agents for good—acquainting themselves with pending legislation concerning mother and child welfare, reporting to their larger groups and getting action when that was necessary.

The part the Woman's Auxiliary plays in the program of educating the people generally in Child Welfare is a big and important one. Very often members of the organization are called upon to meet with groups of women and tell them exactly what the Infant Welfare Society does, and why. They must know something of the history of the movement, and be able to give the message convincingly.

Any community doing Child Welfare work has a supply of material for interesting pictures from which stereopticon slides can be made, and hundreds of people reached in this very telling way. Part of any educational publicity program carries with it an obligation to reach the press. People generally want to be intelligent in their giving and any organization doing Child Welfare work need come with no apologies except as they have not the courage to demand for every mother's son the thing for which they would fight and bleed and die rather than have their own deprived of the inalienable rights of childhood.

The spirit of so generously sharing good things surely counts tremendously for the welfare of children and carries the Society ever onward in its educational endeavor, that of securing for mothers the knowledge of child care and for every child the possibility of adequate medical supervision.

Uniform Height and Weight Tables

THERE having been much discussion regarding the various height and weight tables for children published by the different organizations, and apparently some confusion and doubt having arisen in the minds of many teachers and health workers regarding the accuracy of the different tables, it has long been felt that it was desirable for the principal organizations which were putting out tables to meet in conference and consider the possibility of adopting a uniform table which would be acceptable to all.

For this purpose a meeting was called in New York on December 3, 1920, by Dr. L. Emmett Holt, Chairman of the Child Health Organization, to which the following organizations were invited:

American Child Hygiene Association.

Child Health Organization.

Federal Bureau of Education.

Federal Children's Bureau.

McCormick Memorial Fund.

Nutrition Clinics for Delicate Children.

Public Health Service.

School of Public Health, Yale University.

The following persons attended the conference: Dr. Bird T. Baldwin, Dr. Taliaferro Clark, Dr. William R. P. Emerson, Dr. L. Emmett Holt, Mr Ira V. Hiscock, Mr. Frank A. Manny, Dr. Anna E. Rude, Mr. Sydenstricker, Prof. Edward L. Thorndike, Mrs. Ira Couch Wood, Dr. Thomas D. Wood, Dr. Robert M. Woodbury.

The various tables now in use were critically considered and it was found that there was substantial agreement in the figures used by all, the difference in the tables being chiefly a matter of presentation or statement.

Doctor Baldwin was appointed a committee to draft a table embodying the suggestions made, to be presented to the representatives of the organizations at a subsequent meeting to be held within the next few months, before its final adoption and publication.

Rural Infant Clinics

How Can a Public Health Nurse Organize Them

Zoe La Forge, R. N.*

Children's Bureau, U. S. Department of Labor

IN considering my subject, the different viewpoints gained by placing the emphasis variously upon its phases are illuminating in revealing the difficulties which beset an attempt to reduce them to simple terms. For example, first: Can a "public health nurse" organize "infant clinics;" why not a physician or a social worker? Has a "nurse" ever done so successfully? Second: How may such clinics be organized? What is to be the method and the means? Third: Why "infants clinics" only, when such serious health problems exist as malnutrition among school children, and tuberculosis? Can "specialization" be carried into the country? Why "clinics?" Do we use this term in the sense of its common application in cities? And, fourth: How is such an end to be achieved, especially in rural communities? What do we mean by a "rural community?"

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*Read at the Annual Meeting of the American Child Hygiene Association, St. Louis, October 13, 1920.

We shall assume at once that our discussion will apply to the possibility of such organization in rural communities, since infant clinics in cities have been the subject of the skill of professional and administrative organizers for a considerable length of time and have thereby obviated the chief reason for the projection of the nurse into the field of administrative organization.

It may be well to state at this point our conception of the principle of successful organization, viz., first, a consideration of the elements of an investigation; second, a plan or scheme; third, a trial of the plan, and fourth, the correction or modification of the plan as the result of experience. To the questions outlined above, we shall attempt to offer answers, which are necessarily tentative in view of the limited experience in the field the topic suggests.

WHAT IS A RURAL COMMUNITY?

Let us consider first what we mean by a rural community. The U. S. Bureau of the Census classifies as such "all places or districts having a population less than 2,500." The Standard Dictionary defines community as a "body of persons with common interests." Dr. H. N. Morse, of the Presbyterian Board of Missions, at a meeting of the National Conference of Social Work, offered as a tentative definition, "the unit of territory and population characterized by common economic and social experiences and interests." Still another definition of unknown authority is, "a group of farmers with a common trading center as opposed to a trading center surrounded by farms."

The trading center is a development of rural community life and is dominated by it, rather than dominating or controlling it. The one time trading center grown to a village, and having developed common interests apart from the agricultural groups around it, is still rural in the sense of having a limited population. Clearly the limitation imposed by the definition of a rural community as a "group of farms" is too narrow. It is more properly a neighborhood or a group of neighborhoods, with a spirit and characteristics in direct relation to the characters and leadership of its citizens. Since communities may be more accurately measured by population than by types or characteristics, and in the absence of defined boundaries for a unit of territory, we shall accept for the purposes of our discussion the definition of the Census Bureau, viz., "all places or districts having a population less than 2,500."

DISTRIBUTION OF RURAL CHILDREN

The isolation of the rural child and the difficulty in indentifying him with a tangible group have belittled his importance in mere numbers in the public mind. In the face of the positive and dominating identity of cities, it is hard to believe that sixty per cent of the

children of the United States in 1910 lived in the country. About six and a half millions of them were children under five years of age. Distributed among the large geographic divisions of the country, three and a third millions of these very young children lived in the Southern States, nearly two millions lived in the North Central States, slightly more than seven hundred thousand in the New England and Middle Atlantic States; while the remainder, approximately four hundred thousand, were in the Mountain States (Wyoming, Utah, Colorado, and New Mexico) and the Pacific States (California, Nevada, and Arizona). There are wide differences in the composition of the child population and in the character of the problems in these geographic divisions. For instance, nearly one million of the children under five in the rural South are negroes; and in the Western States (the Mountain and Pacific divisions) where children under five are about half as numerous as in the New England and Eastern States, the area in the smallest State in the Western group exceeds the area of all the New England States together. Thus isolation and the problems of transportation are many times greater in the West than in the East. These facts are cited mainly for the purpose of making clear the nature of certain problems involved in planning a health service for infants and young children living in the rural districts of this broad land of ours, and the necessity for the full consideration of local conditions.

THE COUNTRY DOCTOR

Before consideration of ways, methods and means of organization, let us ask next if a public health nurse can organize such a health service? If she can, should she do so, and why? Why not a physician or social worker? The country has few social workers when one includes in this group only those persons with training in the field of professional social work; they are therefore excluded from consideration here. The country doctor has long been a member of the rural neighborhood; he is pledged by his training and by his Hippocratic oath to the relief of suffering humanity; in many instances he has devoted a long life to this end. The emphasis of this generation upon the new public health, apparently sweeping aside the old regime as unavailing and unprofitable, has turned his reflection upon these rewards for long preparation and a lifetime of service to something akin to bitterness, and has engendered a lack of sympathy, misunderstanding and even open hostility which may effectually defeat the aims of the newer program. The country physicians are frankly interested in pathological conditions; the prevention of disease is considered an academic question. Their training and their practice has been in terms of individual cases of sickness and not in terms of community or public health.

PUBLIC HEALTH NURSES

How are these men to be won to ally themselves with the cause of public health? As Miss Marriner, of the Alabama State Board of Health, has recently well said: "Apparent disparities of interest, such as that between preventive and remedial medicine, may be disproved in practice by showing that good preventive work but offers to remedial medicine a wider reach and a better grasp of its own field, and makes possible the practice of medicine upon ever higher planes of effectiveness." We believe that the public health nurse, through the organization of health services in the country, may so demonstrate good preventive work as to harmonize these conflicting interests, creating mutual sympathy with and understanding of aims and motives.

A TYPICAL RURAL CLINIC

As an illustration of this point, the rural clinics carried on in Kalamazoo County, Michigan, under the Red Cross County Nursing Service at intervals during 1920 are of special interest.

The county is approximately square, with an area of 562 square miles. The rural population is about 20,000, which includes the entire county with the exception of the city of Kalamazoo, the county seat. The six villages range from 300 to 1600 in population.

The county was districted among three nurses, two of whom lived in the county seat, the third living in the central part of her district.

The services of the nurses extended to children of all ages, the larger proportion to the examination of school children, among whom the usual kinds and numbers of defects were found. The chief factors in the problem of rendering a health service for these children were, first, transportation difficulties, the short season of good roads, and the relatively large area to be covered by one person in that time; second, the inaccessibility of expert professional service for diagnosis and treatment, and, third, the natural tendency on the part of the country parents to look upon the correction of defects more or less as "new fangled notions" and to postpone consultation with their physician until a more convenient season even for the more urgent cases.

All of these factors were sufficient reasons for the organization of group service for the children and accordingly the rural clinics were developed.

The health needs of the school children were discussed with the local physicians and the possibilities of a local clinic suggested to them. They were asked to name the specialists and other physicians with whom they wished to serve; these included an oculist, an ear, nose and throat man, an expert in infant care and one in tuberculosis, all of whom, when interviewed, were willing to serve without charge. On the clinic day, the local physicians acted as hosts to the visiting men and received patients in the division known as the "Clearing House Section," from which they were assigned to the various specialists.

The three rural nurses were on duty assisting at the different stations. One of the number with a special aptitude for infant care was on duty in that department the entire day.

Lay women from the neighborhood kept the records of the physical examinations and the recommendations for treatment on special printed slips provided with carbon; one copy was kept by the nurse and the other sent to the local or family physician.

The clinics have been held in the larg-

est school house in the community which usually embraced several school districts. School has been dismissed for the day, the teachers either joining in volunteer service or taking the opportunity for teachers meeting with the county school commissioner. A general program has been provided for the entertainment of the fathers and mothers while awaiting the examination of their children; music has been furnished by the normal school of the county seat and a popular speaker, known at least by reputation in the county, has given a lecture. In the evening stereopticon slides on a general health subject have been shown, the machine having been connected by means of extension cords to the nurse's automobile, when electricity was not available locally.

Notices of the clinic were sent home by the children and posters of bill size giving the full program for the day were distributed in advance throughout the community. These announcements carried the item that the families were invited to bring a pot-luck dinner and spend the day. Four such clinics have been held in different parts of the county this year with attendance running into the hundreds.

The director of the nursing staff moved freely among the different groups during the dinner hour, conversing with many but in the main listening for interpretations and reactions of the clinic upon individuals. In general, there was an absence of the usual extreme sensitiveness and reticence in discussing the health problems of individual children, and a tendency to consider them as health problems common to the group; a real beginning of thought upon health matters as the concern of the community, offering a basis of team thinking which might serve later as the foundation for group action.

The immediate results of the clinic were two-fold; first, the local physician was more firmly established in the confidence of his patients. In several instances, his own diagnosis of incipient disease had been corroborated by the specialist and his instruction regarding treatment and care emphasized and enlarged upon. Second, the local physician was aroused to his own need for newer, more recent knowledge in the field of medicine, both preventive and remedial, and his contact with experts in special fields proved both stimulating and educative. His attitude of benevolent toleration toward the public health program has by degrees become a positive one of open-mindedness and cordial co-operation.

The establishment of this wholesome and desirable relation with the local physicians and the hopeful beginnings of team thinking and community participation in health programs seem to me fully to justify the organization of such rural clinics. Their success has been due in large measure to the leadership, the administrative ability, and the high ethical standards of Miss Trafford, the nurse-director of the Red Cross County Nursing Service of Kalamazoo County.

Aside from those two notable achievements, the fact should not be overlooked that diagnoses were made and treatments either begun or planned for a large percentage of children with physical defects. Attention is called to this point as evidence of our belief that the time has passed when public health organizations are willing merely to examine the same children year after year and to compile reports of their uncorrected physical defects.

FAMILY HEALTH SERVICE

The limitation of the clinic's service to infants seems undesirable when other experts are available, mainly for the reason that

the rural mind more readily comprehends a family health service, such as for example the performance of the public health nurse in caring for all members of the family when illness occurs. The parent, and in Kalamazoo, fortunately, both parents, sees the relation established between the expert and the local physician and the public health nurse. It is not so certain that the organization of infant clinics alone would prove so effective a medium for making these relationships clear. The convenience of the family living in the country is also to be considered. Parents will willingly devote a day to such a program as that of the rural clinics just described; on the other hand, if the mother were asked to take the baby one day, the school child another, and perhaps to go to the doctor for herself at another time, it is probable that with genuine regret she would be unable to comply. The degree to which specialization can be applied in country districts is necessarily limited, but there seems to be no sound reason why its benefits may not be made available through some modified form or organization hitherto untried or unthought-of.

HEALTH CENTERS AND CLINICS

For the rural community with resident local physicians having access to the service of experts and specialists at least once a year through the organization of rural clinics either general or limited in their service, the experience of Kalamazoo County may prove suggestive and illuminating. But rural communities with such advantages are commonly the exception rather than the rule. In the South, the Middle West and the Far West are many counties with no small town as a poulation center from which expert assistance might be drawn. For such communities the organization and maintenance of an educational and nursing service through health centers seems possible and practicable. There is at present such confusion of nomenclature in the public health field that a definition of the terms clinic and health center seems important. The term "clinic" we interpret as applying to places for the diagnosis and treatment of illness among ambulatory patients. By "health center" we mean a place where any health service may be rendered; it may include a clinic, a dispensary, a loan closet, a demonstration station, a laboratory or a nursing service, or all of these things; nutrition classes, little mothers' leagues and real mothers' clubs may hold meetings there. In brief, it may be the pivot about which the health activities of the community revolve.

AIM OF HEALTH SERVICE

The fundamental principle upon which successful health work in the country depends is that the health of its citizens become the concern of the community rather than of one professional group; that the ultimate aim of the health service be the development of posi-

tive vital physical well being rather than the mere absence of disease. Country people are still uniformed about much of the public health movement, and the best means for their education is an active participation in the establishment and conduct of a service for which they are convinced of the need and the subsequent development of other services as the need for them is appreciated.

The health services which the nurse may render at such centers either with or without a medical attendant are (a) the periodic weighing and physical inspection of children, particularly those under school age; (b) consultation with mothers on the care, feeding and general hygiene of children; (c) consultation with pre-natal mothers on the hygiene of pregnancy; (d) demonstrations of preparation of foods, the preparation of maternity supplies, and the simple procedures in the home care of the sick.

DOCTORS AND HEALTH CENTERS

The adjustment of the relation between the health center and the local physicians has been the most difficult problem; it has been the rock upon which a number of health centers have foundered. Rotation of physicians by periods varying in length has been tried, frequently proving unsatisfactory for the reason that the physician on service is unable to carry his patients entirely through to a satisfactory outcome and that the patients of one physician are seen by other men. Physicians have hesitated to serve for another reason also, viz., that the numbers of patients seen at such centers who are in urgent need of medical service are too small to justify the amount of time the medical man spends there. They have suggested as a substitute plan to obviate these difficulties the following: they will see at their offices during regular office hours any patient whom the nurse may send to them from the health center; they have offered, furthermore. to give full consideration to reports of the nurse upon the financial and social condition of the patient. By this means, the health center maintains its status as an educational and nursing station; patients remain under the care of their family physician either with or without payment of a fee; the nurse is at the service of all the physicians in the community; and the opportunity for differences of opinion regarding assignments of patients and allotment of medical service is reduced at least to a point of safety.

There seems to be slight hope of securing experts for these communities except through their employment by state departments of health, or private state or interstate organizations. Such specialists may hold conferences at intervals which may well serve as institutes for local physicians and public health nurses.

"BEDSIDE CARE"

The mothers and children who

come to the center are naturally recruited from among those whom the nurse cares for at home. The most effective means of gaining immediate confidence of country people is by giving bedside care to sick patients. Since it is not possible to carry out the usual visiting nursing service for the sick in rural communities, such a program is necessarily limited in its application. For example, maternity nursing has been and is now being successfully given in some parts of Kent County, Michigan. The service speaks for itself; it needs no propaganda and carries the opportunity for teaching infant hygiene in the home, with continuous supervision of the babies through the health center.

HOW TO INTEREST THE PUBLIC

The participation of rural citizens in the establishment and conduct of the health center may be cultivated by providing specific and concrete services which lie within their understanding and capacity to perform. A most important part of the nurses' duty is to plan a definite program or schedule which includes the addition of other services from time to time as their interest and experience grows. One of the simplest of these functions which a lay group may perform is to establish and maintain a loan closet containing necessary supplies for use in the sick room. This is particularly useful for maternity cases when sterilization facilities are not readily available elsewhere in the community. The supplies are also useful for demonstration purposes in classes in home nursing. The greatest value of the loan closet lies in its obvious usefulness, a very effective educational medium to introduce further activity on the part of the citizens in the work of the health center.

Another service which the lay person may perform is to make copies of birth certificates as they are filed, upon attractive forms to be sent to the parents of newborn infants. Mothers who do not receive such a return upon the birth of their children, when the custom has become established, may be depended upon to question why. Although the bulk of such work in any rural community is relatively small, it is nevertheless continuous and emphasizes birth registration with quiet force. Other services than these will occur to the resourceful nurse, whose aim is the development of a progressive team-thinking, team-action program.

It seems clear that the successful organization and administration of a rural health service for mothers and babies is dependent upon the qualities and leadership, executive ability, mature judgment and high ethical standards in the nurse so engaged. But a nurse so gifted will be unable to harmonize the present conflicting interests between preventive and remedial medicine alone. She must have the active support, encouragement and enthusiasm of the specialists in the field of infant hygiene. In behalf

of the rural nurses and the new divisions of child hygiene and public health nursing recently organized in many of our states, who will work in the main in rural communities, the appeal is here made for the enlistment of such service by these experts.

Give The Young Mother a Chance

Vera Cober Rockwell

[Editor's Note: The following article has been sent in as a plea from the present generation of young mothers, and is recommended to the thoughtful consideration of grandparents.]

IT was six years since I had last seen Nellie, six long years, and now—grandmothers! It seemed too ridiculous! Why, it was only yesterday that we were blue-ginghamed babies together, climbing, in spite of thick, pudgy legs, and parental protests, over the high, awkward fence that separated our homes. What fast little friends we were as schoolmates and later, how happy as young brides and mothers! Our friendship had never wavered an instant since the blue-ginghamed hours of that yesterday, and now—grandmothers!

To prove it, there in the open doorway stood Nellie, a lovely wide-eyed grandson on her arm, who gravely watched my suitcase as I, in spite of my fifty years, almost ran up the porch steps. She was the same old Nellie—I could tell that at a glance—with dancing black eyes, dimpled cheeks, and hair only a wee bit gray. How my heart leaped at the sight of her! And that dear baby!

"Elinor is gone for the day," she replied to my query about her daughter, "so I am playing nurse."

"Isn't that fun!" I rejoined enthusiastically. "I always feel like a young, new mother when Virginia gives me that privilege. Baby Marjorie and I get on famously together. She's the happiest little thing—just ten months old today."

"She must be a darling!" exclaimed my old chum as she led me into the cozy living room, motioned me to a chair, and plumped the baby down in my arms. "Gordon and I have a great time, too," she laughed. "Don't we, honey?" The little fellow gurgled, and jumped in ecstacy as Nellie bent over him in play.

"When the cat's away, you know!" and she winked knowingly at the baby. Then catching my puzzled look she explained gaily, "Elinor is fussy with her baby, Jane—positively fussy. She's so strict with his diet, and sleeping hours, and all, and it's such nonsense. Why, if she were here, baby would be in bed fast asleep this very minute and not down at the door to welcome Auntie Jane whom

he's never seen before, bless her!"

"Nellie!" I gasped in astonishment, "You didn't keep him awake just for me when you knew I came prepared to spend a week with you!"

"Oh, no," Nellie answered lightly. "I didn't keep him up, but I did awaken him when I heard your train coming in, and slipped another dress on him. He had slept enough to last him till night anyway."

"Now listen, Nellie," I admonished her, half jestingly, half seriously. "Don't you ever wake that baby up again for me. He needs every bit of sleep he can get. Besides," I added with a laugh, "I can assure you I would never return the compliment for you."

"Oh!" said Nellie with quick sympathy, "Is Virginia fussy, too?" and then not waiting for my answer, placed Gordon in his playyard, "Now be a good boy for Auntie Jane," she coaxed, "and we'll get her some luncheon in a hurry."

At table, Gordon sat in state in his handsome high-chair.

"He's beginning young," I remarked, as Nellie fastened a snowy napkin around his neck and prepared to feed him. "He isn't eight months old yet, is he?"

"Next week, the twentieth," explained my hostess. "We don't give him much besides his milk. Elinor feeds him every three hours and then in between times I insist, in the face of her protests, that we give him old-fashioned pap, milk thickened with cornstarch, you know. I used to feed it to Elinor, so, of course, it's all right. Then when he sees us eating, naturally he wants to eat, too, so we give him—or rather I do—a little piece of bread to keep him quiet. Elinor did not want to begin feeding him solids yet, but I told her she was foolish to put it off any longer—he has to begin sometime—and he might as well be starting little by little. So now she lets me go ahead with the pap, and days like this when he and I are alone, he gets a little taste of everything and nobody's the wiser. Now this scalloped potato is so tender and tasty, I know he'll like it," and she put a small bit between the baby's eager lips.

To see that darling baby, without a tooth in his head, rolling the potato around in his little mouth, and then swallowing it whole, to see him choking over wads of soft bread, was shocking to me. My appetite that had been so keenly whetted by the odor of Nellie's cooking, fled. I wanted to protest, and yet I did not want to hurt dear old Nellie. But I could not keep still.

"Nellie," I said and she looked up in surprise at the pleading note in my voice. "Nellie, dear, don't you think you are taking a terrible responsibility upon yourself?"

"How?" she asked in astonishment.

"Well—in imposing your ideas upon Elinor. It's her baby. Why should she not have the privilege

of bringing him up as she wishes. You brought yours up—"

"As my mother wished," interposed Nellie, quickly.

"Yes, and very probably she brought hers up as her mother wished," I continued. "Don't you see what that means? We've been using home grown and ingrown methods of culture for our babies for years. It is only recently that there have been physicians who realized the need of specializing in the development and growth of children. Don't you think it smacks of Chinese ancestor worship to cling so stubbornly to the old ways instead of admitting possible good in the modern ways? Aren't you willing to try out the new ways?"

"Jane!" exclaimed Nellie, in growing astonishment. "You amaze me! Those Red Cross lectures you have been going to have certainly put a lot of new notions into your head, and style, too! But I see what you mean. At the same time, I've got a pretty fair specimen of the good old way in Elinor. She is so strong and healthy."

"Has she lost her old nervousness?" I could not help asking.

"No—she's extremely nervous," admitted Nellie. "But you can't say that was due to my feeding."

"No—I cannot say so; but disorders of the stomach so quickly affect the nervous system that we cannot say definitely that it was not that, until we prove positively that it was something else. Don't you see? In the same way I cannot prove that the sick headaches Virginia has been subject to all her life were not the result of my ignorance of how she should have been fed. The whole thing resolves itself into this. If Elinor rears her child by careful feeding and modern methods and then discovers he has some weakness or other, at least she knows that she is not to blame—she has done her best. And if you have not interfered, you too, are blameless."

Here I hesitated a moment. It was hard to give utterance to that which had lain voiceless within my heart for so many years—but I felt that I must drive the point home.

"Nellie," I said softly, "You remember my baby boy? You remember he was just a year and a half old. Did you know—" again I paused. The hurt of it was so poignant, so fresh after all these years, and it seemed somehow traitorous and unfilial to tell the story. "You did not know" I began again, "that it was my mother's insistence upon wrong methods of feeding him that took him away from us? Poor, dear mother! She worried and grieved over her interference all the remainder of her life. I was young and inexperienced, she thought her way was best, and I followed her advice."

Nellie's cheeks paled as she looked at me with startled eyes.

"Poor, dear Jane," she said after a pause.

"And poor dear mother!" I said

again. "The fault was not hers after all. How could she know? It is so recently that mothers have been given intelligent solutions of their problems. In earlier times people did not have such sources of expert knowledge as we now have in magazines, and handbooks, and as specialists can give. For the most part, I believe young mothers today are eager to look around and absorb this knowledge, but in far too many cases we older mothers won't give them a chance. Does it seem fair, Nellie?"

And Nellie, who was always the frankest, finest pal anyone ever had, said quite candidly, "No, Jane. I believe you are right. Only I am just a wee bit jealous because I did not figure it out for myself."

The Maternity and Child Welfare Bill

ON December 18 the Sheppard-Towner (Maternity) Bill passed the Senate of the United States, and public hearings were begun on the 20th before the House Committee to which the bill was referred. These hearings have been unexpectedly long and at the moment of going to press they are still in progress.

It has been commonly stated that practically no new legislation would be considered by Congress at this short session, particularly no bills carrying appropriations. The passage of the bill through the Senate and its consideration by the House Committee indicate the great measure of interest which has developed throughout the country.

Very interesting testimony as to the urgent need of measures for the protection of mothers and babies has been given at the hearing. Following Miss Julia C. Lathrop, Chief of the Children's Bureau, appeared Dr. Richard A. Bolt, Director, American Child Hygiene Association; Mrs. Florence Kelley, General Secretary, National Consumers' League; Dr. Edgar L. Hewett, American School of Research, New Mexico; Miss Elizabeth Fox, Vice-President, American Public Health Nurses' Association; Miss Jeanette Rankin, former Congresswoman from Montana; W. F. Bigelow, Editor, *Good Housekeeping;* Mrs. Miller P. Higgins, President, Congress of Mothers and Parent-Teacher Association, and Mrs. Maud Wood Park, representing the National League of Women Voters, and other organizations which have endorsed the bill.

MOTHER AND CHILD
A Magazine Concerned With Their Health

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JANUARY, 1921

The Endowment of Ideas

CAPTAIN THOMAS CORAM, a bluff old sea-dog, who lived a very active life, established in 1741 the London Foundling Hospital. He died in an almshouse ten years later, and his institution meanwhile was undergoing a desperate struggle for existence. Finally, Parliament in 1756 voted that all children brought to the hospital should be cared for, and funds were provided for that purpose. In the ensuing three years, over fifteen thousand children were received, and out of that number, over eleven thousand perished. The total cost of this experiment in wholesale institutionalism has been estimated at half a million of pounds. Captain Coram's foundation, measured in terms of economic benefits, was a failure. Even as a failure it failed, since it did not successfully impress upon the public mind the lesson that the institutional care of the child may be fraught with peril not only to its health, but to its life.

Endowing buildings and neglecting the endowment of brains, is a practice not peculiar to the eighteenth century. It is still with us. For a long time, indeed, society has believed that institutions and agencies can take the place of individual responsibility and individual thought in disposing of social problems. In spite of colossal failures like that of Captain Coram's hospital, we are still inclined to think that our social responsibilities, and especially those involving the care and up-bringing of children who are the wards of the State or municipality, can be disposed of by placing them in institutional pigeon-holes—and then forgetting about them. Occasionally an institution is found where an executive by exercising nothing short of a sort of genius for organization secures an amazing achievement exemplified not only in a lowered death rate, but also in a degree of physical robustness not usually seen in institutional children. But this result is so rare as to be almost a phenomenon.

It is too much to expect that the convenient expedient of the institutional care of orphans and foundlings will, even in our day, be totally abandoned. Nor can it be denied to the advocates of institutional care, that the unsupervised boarding out of such children in private families may not be used

by unscrupulous persons to the detriment of the child. Proper investigation of the homes, and adequate supervision of the health care of these charges are necessarily postulated if the boarding-out system is to supersede the mass care of children in institutions. But the day should soon be here when individuals who endow institutions for child-care must realize that the mere provision of land and buildings is not enough, and that a further endowment of ideas in the shape of an executive staff trained in proper standards of hygiene and nursing care is after all the most important thing. When the State assumes the care of a child it incurs all of the moral obligations of a parent, and when it turns its charges over either to an institution or an individual, the duty of the State, far from being ended, has only begun.

Education of the public to a realization of these facts is one of the many needed tasks of child hygiene endeavor, and it is in this field that child hygiene work is preeminently educational work. Because of the great need for a wholesome diffusion of ideas concerning proper standards of child-care, not only for children who are public wards, but for children of every social condition, the American Child Hygiene Association was organized eleven years ago. Composed originally of physicians, social workers and nurses, it now includes in its membership a large number of persons not professionally interested in public health.

No individual could, alone and unaided, spare either enough time or enough means to successfully teach even a small portion of the public what it should know concerning child health. No fact is more obvious than the supreme importance of intelligent direction in the movement for preserving the life and health of the children of the United States. But every member of the American Child Hygiene Association is amply justified in feeling that he or she, by the very fact of membership, is accomplishing something toward the endowment of ideas on all the phases of child welfare.

—JOHN A. FOOTE.

Ethical Advertising

Inquiries have come as to why MOTHER AND CHILD has not included advertising in its pages. The management of this publication feels, since the decision to solicit advertising matter has been made, that the same scrutiny and the same ethical standards which apply to material submitted for the reading pages must also govern the acceptability of statements made by prospective advertisers. We cannot do less than this if we would be consistent in our mission of health education.

Honorary Members

At the eleventh annual meeting of the American Child Hygiene Association, the following persons, all of whom have rendered distinguished service in the fields of Child Hygiene, were elected to Honorary Membership:

J. W. Ballantyne, M.D., F.R.C.P., F.R.S.E., Royal Maternity Hospital, Edinburgh.

Benjamin Broadbent, C.B.E., J.P., Huddersfield, England.

Janet Campbell, M.D., Senior Medical Officer, Ministry of Health, England and Wales, Division of Maternity and Child Welfare, London.

Prof. Louis Guinon, Physician-in-Chief, Hospital Bretonneau, University of Paris.

Herbert Hoover, American Relief Administration; Chairman, European Relief Council, New York City.

F. Truby King, K.C.M.G., M.D., B.Sc., Dunedin, New Zealand.

Janet E. Lane-Claypon, M.D., D.Sc., King's College, University of London.

Sir Leslie MacKenzie, K.C.B., M.D., F.R.C.P., F.R.S.E., Member of the Scottish Board of Health, Edinburgh.

Prof. A. Pinard, Professor of Obstetrics, Faculty of Medicine, Paris.

Dr. Rene Sand, University of Brussels; Secretary of the Educational Foundation, Commission for Relief in Belgium.

Dr. B. Weill-Halle, Ecole de Puericulture, University of Paris.

The Foreign Field

Provision for the Health of Mothers and Children

Italy

Organized Child Welfare

"An Italian Bureau for Child Welfare has been organized in Rome, to which belong the Italian Red Cross, the Italian Women's Catholic Union, the Societa Umanitaria, the most powerful welfare association in Italy, with headquarters in Milan, the Maternity and Child Welfare Society, and other important associations which are mainly concerned with Child Welfare.

"This Bureau will endeavor to develop, to encourage and to make known all institutions already existing in Italy, as well as enlisting public sympathy in favor of the protection of the infant during the pre-natal period up to the end of the compulsory school period (elementary schools).

"It is also the object of this bureau to promote among the heads of child welfare institutions the frequent exchange of ideas regarding the practical results obtained, so

that, benefitting by example, all these institutions may give a bigger impetus to their various activities, co-ordinating them more closely towards the common end, which is the protection of the mother and the child.

"In order to realize this object, this new institution proposes, with the aid of the Government and of affiliated associations, to investigate all institutions having the same end in view, and will use its influence with all authorities which have charge of public or private teaching institutions, both religious and charitable, in order that courses of maternity and child welfare may be included in their programs.

"'This Bureau will be directed by a Board of Governors under the Chairmanship of Senator Ciraolo, President of the Italian Red Cross."

(From the Bulletin of the League of Red Cross Societies, 1920, i, xii, 13.)

Serbia

A Sanitary Train

The Belgian Department of Child Welfare gives the following description of a very complete traveling children's clinic operating in Serbia:

"On the initiative of the Minister of Public Health, a sanitary train has been equipped, composed of six coaches planned to serve as an ambulent dispensary and as a means of propaganda. In all the villages through which the train goes, public meetings on health are held, accompanied by moving picture illustrations. Two coaches contain bath rooms, and isolation rooms with arrangements for disinfection, which can accommodate 2,000 people a day. There is a special room for contagious diseases, a bacteriological laboratory, and a second isolation room, as well as sleeping and dining rooms for the personnel. All the coaches carry the insignia of the Red Cross. This medical service brings aid, rapid and practical, to villages distant from the large towns."—(State Charities Aid Association News. 1920, ix, i, 6.)

France

Popular Health Education

PROFESSOR A. LESAGE,
Physician to the Paris Hospital

IF one wants to do everything one cannot do very much. The problem is to spread among the masses of the people the elementary rules for bringing up of infants. The working-class mother should know the right way of bringing up her child. The purpose of my article is to study a way of limiting the means to be used so as to concentrate the efforts and obtain the maximum of results. Everything which is complicated, or the value of which has been incompletely proved, should be eliminated.

We must tell the mother what she should do, but also what she should not do. Popular prejudices must

be combatted. And we must fight against the old women who in spreading those prejudices are doing the wrong kind of health publicity.

It is necessary to fight against the idea cited by Cabanes: "My mother did that; my grandmother did likewise, and we are not any worse off for that."

Popular education requires slow, continuous, and repeated efforts. Any thought in order to reach the masses must be repeated a hundred times. Let us not make the mistake of trying to teach everything to the working-class mother and trying to make a learned or half-learned person out of her. Let us use simple means and let us always put breast-feeding as the basis.

Popular education by means of pamphlets, books, pictures and posters, and other printed matter has been carried on for a long time in our hospitals, maternity homes, and by our child welfare agencies. All this printed matter containing the principles of hygiene is excellent, but who reads it? Is there any mother who has looked once on her marriage certificate on which the instructions issued by the "Academy of Medicine" are printed? These printed directions are oftentimes overdone. Too much is said in them. They frequently contain conceptions of medicine which the reader interprets and applies in the wrong way.

I think it is a great mistake to state in general tables that a child of certain weight, and certain age, must be given a certain amount of milk. The curve of weight which is used by so many people is one example of it. This curve is a line which represents only an average. The physician and midwife understands that, but the mothers do not see it so. They say: "My child is not sufficiently nourished because his curve is below the standard line." Therefore, in order to reach the standard curve, they over-feed the child and do, unwittingly, more harm than good.

In order to avoid this error, the regrettable results of which are seen daily, a new curve has been decided on which is called the "path of life." Instead of showing only one line which the child must follow, the curve consists of two lines, and the child's curve may be between them. If his curve is below the lower line, the child is ill, if it is above the upper line, the child suffers from obesity.

The use of a nutrition index for all infants always seems to me regrettable because there are no ideal children, or a prototype of children. I observe daily the bad results of this bringing-up according to mathematics. The mass of people do not understand it and follow it wrongly when they do. It is too high-brow for a working-class mother. It is all right for a student or a midwife who regard the figures as an average, but we must remember here that in this article I am concerned entirely with the working-class mother. In my

opinion it is entirely sufficient if she knows that her child must be followed up and examined once a week, or once in two weeks; that it must be brought up according to rules, and cannot be given any medicine except when the physician himself prescribes it. More should not be demanded of her. In a word, as regards popular education, much should not be expected from all the printed matter. Possibly in the long run one thing might have an effect, and that is, to distribute abundantly in all the schools and child welfare agencies simple postal cards, each of which should have a picture of two children, one well developed, brought up by breast-feeding, and the other a weakling, a bottle-fed child. Each card should have the following inscription. "This is the result of breast-feeding, and this of bottle-feeding." The little girl will pin this card to her bed in her room. She will see it each day and finally will remember the inscription.

Popular education by lectures has been recommended, but all the persons who took part in the lectures concluded that they were useless. The working-class mother does not go there because a lecture very soon puts her into a sweet slumber.

In Paris we thought it advisable to interest the public by moving pictures. We have come to the conclusion that these amount to very little. It is only a picture of a child, but not a living child, one that can be seen at an infant consultation center.

Popular education through the press has been recommended. It is evident that the people believe what they read in "their" papers, but the working-class mother reads only the miscellaneous events and especially the novel given in the paper. She will perhaps read once an article on the bringing up of the child, but she will not read it again if she sees it several times. The woman reader wants news for her money. Let us admit that the woman does read the article. She will not see what the article speaks about because it is very difficult for her to visualize all the author has to say.

It has been suggested that future mothers be taught at school by means of purely theoretical lectures on the bringing up of children. This no more serves the purpose than does the theoretical teaching of sewing or of domestic science. Madam Pasky recommended that to these lectures object lessons be added by means of dolls. This may be all right, but why not accustom the young girl to handle a real live child, of flesh and bones, one who cries and laughs, and why not accustom her to listening to the advice of a physician holding a child in his hand, to seeing the child weighed, and so forth?

For child-care before confinement, pregnancy consultations are the really practical school. The working-class mother meets there other women like herself, she hears the physician say to her neighbor, "You are in the sixth month. You

must take such and such precautions. Come in a month and bring a sample of your urine." The mother gradually learns through her eyes and ears the good ways of caring for herself during her pregnancy. It isn't a lecture; it isn't a picture, but a practical thing, seen, heard and proven.

Then the mother has her child. She knows that in the same house where the pregnancy consultations are taking place there is also a consultation center for infants. She has been there and goes again with confidence. The consultation is an object lesson. Once a week the mother takes her child there. The physician's questioning compels her to watch her infant during the week or two weeks before her visit there. She learns to observe and to think and she comes to realize the importance of weight. She is very much pleased if the weight is good, and is disappointed if the child remains stationary or loses. She listens to the physician who tells her to feed the child so many times, to give it so much milk, and so forth, and who calls her attention to her offenses against the rules of hygiene.

She realizes the importance of regularity of feeding and understands the danger of bad milk, the need of sterilization, and so forth. Gradually the rules of hygiene become familiar to her. She makes comparisons and notices that the breast-fed child is sometimes smaller than the bottle-fed child, but he is better looking, more solid, and is rarely ill.

The physician can accomplish much by working on the mother's pride, either by a compliment or by silence, or a rebuke.

The rivalry between mothers is the best indication of the fact that a common knowledge of the rules of hygiene begins to reach the masses of people.

Moreover, the mother herself becomes one of the best agents of the propaganda by spreading the rules of hygiene that she has learned.

The older girls of the neighboring schools could also come by turns to the consultation to see, listen, and handle the little ones, to study a live child. The future mother would learn in this way the importance of breast-feeding and the difficulties and danger of artificial feeding, and when she would become a mother this former pupil of the consultation would know what to do and would not be put on the wrong track as unfortunately happens to so many young mothers.

It is necessary to teach to school girls the art of bringing up infants. Why not, if domestic science, history of the Kings of France, and dates of battles are taught? This will be a real, practical school where the working mother will learn slowly and almost unconsciously to free herself from all the hereditary prejudices which fill her mind.—(From Oeuvre Nationale de l'Enfance. June, 1920. Courtesy of The Federal Children's Bureau.)

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"The Battle of Tomorrow"

"In the name of the Government of the Republic, I call upon you to participate in the battle of tomorrow, in which you will once more vanquish death, to whose ravages we are constantly endeavoring to set a limit."

In these stirring words, the Minister of Hygiene of France, M. Jules Le Breton, addressed the General Assembly of the Women's Union in Paris last October. He emphasized the vital importance of child welfare in the following terms:

"It is more than ever necessary that France, which has suffered a decrease of her population, should spare no efforts to save the lives of her children, the pledges of her future prosperity. In this field, your efforts may perhaps be even more successful than those put forward by you during the war. It is true that the most insignificant ills constitute a menace to the fragile existence of a child, but on the other hand wonderful results may be obtained by a minimum of care and attention. In earliest infancy mortality may be reduced or even suppressed by prompt care and advice. Indeed, without effecting an increase in the birthrate, and by merely protecting the newly born, it should be possible greatly to consolidate the strength of our nation; such is the task that we are called upon to fulfill."

MOTHER AND CHILD

A Magazine Concerned With Their Health

VOL. 2 FEBRUARY, 1921 NO. 2

The Grenfell Hospital, Bottle Harbor Island.

The Children of the Labrador

V. B. Appleton, M. D.

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CHILD welfare and health education for children in Labrador present almost untouched problems. The data embodied in the present paper were collected during the autumn, winter and early summer of 1919 and 1920. A survey of the conditions and health of children could not be the sole purpose of the author during this time as there was no other physician on a thousand miles of the coast of the Newfoundland Labrador. An active medical service, however, only aided the health program by offering a portal of entry for meeting the scattered population of this lonely district and gaining the confidence and cooperation of a reticent and stolid people.

The territory about a hundred and fifty miles along the Labrador side of the Straits of Belle Isle was our field for action, but a brief visit was made to a group of communities on the Newfoundland side of the Straits, where beri-beri and xeropthalmia were rife. The people are fisher folks, mainly of Anglo-Saxon origin. They are simple, kindly, courteous people, undemonstrative and stolid. Victims of a rigorous climate and often unkind fate, they have become

phlegmatic and are too apt to accept conditions which might be bettered, with the excuse "it must be so on this coast." They live in primitive communities of from five to one hundred and seventy-seven inhabitants, with no form of government nor anything to encourage community spirit, and with very little knowledge of the outside world.

The Labrador (the people there say "The Labrador") is icebound for at least six months of each year. During this period we traveled nearly eight hundred miles by dog team, and about five hundred miles by motor boat. Often it was necessary for the boat to weave its way among pans of ice and icebergs. Landings were made on bay ice, half a mile from the shore. Sometimes we had to travel part of the way by boat, and the rest of the way with dog teams. Several times jams of ice were blown onto the shore, making further progress impossible.

The unusual nutritional conditions, with the resulting deficiency diseases, and the prevalence of tuberculosis were so serious that it was impossible to consider the health of children apart from the health of the whole community; but as in much preventive medicine, work for children is most needed, and most hopeful.

Children attain economic importance early in Labrador. Families are large and the children have to help their parents. Several little girls of ten years of age were found to be taking entire charge of the household work during the illness of the mother. One woman in taking in laundry, turned it over to a little girl of ten. Boys of from twelve to fourteen years of age help with the fishing, sometimes working independently to earn their own clothing and even their food. Even this early entry into economic life does not make children lose their respect for parental authority. Paternal discipline is usually very strict, the youngest child being the exception and very much spoiled until another takes its place.

Educational conditions are deplorable. Illiteracy is general. Only seven out of the twenty-seven communities visited had teachers during any part of the ten winter months. Three others had teachers for a few weeks in the summer. Teachers' salaries are small, so they are neither well trained nor deeply interested in their work. Instead of public schools, there are denominational schools, so a tiny village may have two school houses, neither having any equipment save long benches, often without backs, a small blackboard, a map of Newfoundland, sometimes desks, and rarely a teacher. In one school a group of pupils had collected money to buy a map of the world. Only about half the children go to school even when there is a teacher. This is partly because the parents fail to appreciate the value of education and let children do as they please, partly because of denominational feelings, and partly because a fee is charged, and al-

though small, limits the number of children who can attend out of a large family. A textbook on hygiene is used, but like everything else, merely learned by heart, the criterion being how many times one has been through the book rather than how one lives. This made our task more difficult.

Children do not play; there is a sad dearth of music, very little singing and laughing. Playthings are rare and not played with. The doll population is small, and the dolls are pinned up to serve as wall decorations, rather than as playthings, or objects of affection. The children know no games—they have no sports. We saw only one ball—an old basketball. Children have sleds and sometimes go "for a randy" on them. The men all have snow shoes, but boys get them only when they are old enough to drive dogs, and chop and haul wood. Occasionally a fortunate boy has a team of two dogs of his own and hauls wood and water, while he enjoys the fun of playing provider for the family.

Midwifery is in charge of self-taught women whose qualifications usually consist in having borne ten or twelve children, and in having assisted an older midwife. In the absence of better medical skill, they attend to all ailments. One should not belittle their hard work and honest effort, but ignorance and lack of training together with poverty and lack of equipment have often sad results.

Nutritional conditions on the Labrador presented the greatest need for our health campaign. The standard of living, as far as diet is concerned, is within the danger zone from a health standpoint. Malnutrition is general and deficiency diseases are not uncommon. This is due to poverty, difficulty in securing and conserving supplies, and to ignorance as to what food is necessary for health and normal development.

The season open for navigation is short and the coast dangerous so there are difficulties and delays in securing supplies. If the fishing season is late, supplies may be ordered too late to arrive before navigation closes, and one may be left on almost starvation diet. Gardening is little developed because the season is short and uncertain. The ground is frozen until the middle of June and snow and frost may come even in midsummer.

Important vegetables are expensive. The severe climate makes their conservation difficult. Even very carefully guarded seed potatoes froze last winter; fowls hardly pay, as they lay so small a part of the year, and are always in danger of being killed by the dogs. Eggs are a great luxury. We were four months without an egg. Milk is also scarce. Only a few fishermen try to keep cows. Cattle are fed so little that they do not give milk during the winter. The dogs kill both cows and goats. Furthermore, hay is ready to be cut at the busiest fishing season. But if it is

cut then it means a great loss to the fishing industry. When hay is cut late, after the grass is dry, it has poor food value. Cows eating such hay gave milk so low in vitamines that deficiency diseases increased in the region. Condensed or evaporated milk is bought in small quantities, two cases being considered an ample supply for a family for a year. The diet is relatively low also in vegetables. White flour, salt meat, salt fish, molasses, a little condensed milk, a few potatoes, dried peas, and tea make up the usual diet. Bread and tea is the basis of each meal.

Infants are practically all breast fed. They develop fairly normally during the first year of life, although they are pale and somewhat flabby. In the region where beriberi and xerophthalmia were prevalent, the infant mortality was high. This was in contrast with the region where deficiency diseases were rare, and goes to show that mother's milk contains vitamines only so long as the mother receives sufficient vitamines in her food.

The older children are practically all under weight and under size. Their teeth are of very poor quality and become carious early. This is undoubtedly due to poor nutrition. Even with this degree of malnutrition in children, there is very little rickets. It is interesting to find this absence of rickets even under such deficient nutritional conditions in a region where syphilis has existed only recently and is still rare. This suggests the importance of chronic inflammation as a predisposing pre-natal factor in the etiology of rickets.

Such were the conditions we found in Labrador. Our object in going to Labrador, however, was not to make a survey but to do constructive health work.* We began by organizing recreation and playground work for children. My assistant, Miss Marjorie Jackson, arranged games, exercises, and singing for the school children Saturday afternoons. We invited only school children, to encourage education, and so popular was our recreation afternoon that school attendance increased rapidly. To children who did not know how to play, the simple games were an awakening. "Let's play cat and rat," was always the first cry, though this game had to share honors with "drop the handkerchief." The broad, snowy stretches, or smooth frozen bay made ideal playgrounds. We opened a social center with a Christmas entertainment in which all the children and young people took part, singing Christmas carols or acting in a little play. Later, to scatter the Christmas spirit, we went to another village and helped the children there to decorate a similar Christmas tree, the first they had ever seen. Afterwards Miss Jackson taught the children to play games while I held a medical

*This work was financed by the Y. W. C. A., and conducted by courtesy of the Grenfell Association.

clinic. The affair was as jolly as it was informal, some guests receiving hair ribbons, pencils, or handkerchiefs, and others pills or surgical dressings. For a lonely little group, disheartened by poverty and disease, this unexpected for merry making and play, physical exercise and community spirit. It was interesting to see the children respond to play, the do-or-die expression on their serious little faces as they took their first turn on the merry-go-round changing

Travelling by dog-team.

Christmas merriment had as much therapeutic value as the drugs.

Perhaps the most hopeful result we are leaving behind is a very popular little playground, the first of its sort on the Labrador. There are only two swings and a merry-go-round, but therein lies the seed suddenly into a radiant smile as they felt the thrill of motion and joy.

Special malnutrition cases came for daily exercises and for food in certain cases.

In each village to which we came all the sick came to us and neigh-

bors dropped in to see what we looked like. So quite informally in conversation we preached health and hygiene to little family or neighborhood groups gathered in the kitchen which served as a living room. Sometimes one talked about the care of teeth while one examined or pulled teeth; then we would give toothbrushes to the children, and have toothbrush drills every evening after tea as long as we stayed in the village. The prevention of tuberculosis and puerperal fever, care of the teeth, care of the baby—all the usual subjects, were brought up during the conversation. Finally people brought well children to us for examination. Our favorite themes were the need of milk and vegetables, because nutrition is the basis of all health problems on the Labrador—bad teeth, indigestion, constipation, malnutrition, deficiency diseases and tuberculosis. The diet is deficient in foods containing vitamines, the growth producing and protective substances necessary for normal growth and well being. One must raise the standard of living by showing the people what are the essential foods, and how to get them. We chose milk and vegetables as the most essential foods lacking. Of course we had to prove that a cow can be made to pay. Fortunately, we had a cow—she was a thin, rough creature and had nearly starved to death the previous spring. Ordinarily she gave only about a cupful of milk a day in winter and none at all in spring. We converted her into the demonstration animal in our experimental station and proved that with proper feeding she could be made to give from two to two and one-half quarts a day throughout the winter and spring. She had her first living calf this summer as a result of proper care and feeding.

We planted an experimental window-box garden, and had quite an exhibit by the end of April when we held a Nutrition Conference where our guests discussed "cows and milk," "poultry and eggs," "gardens" and the improvement of that very necessary beast of burden, the dog, who is an enemy to them all. We demonstrated the making of hotbeds and coldbeds, and better methods of gardening. We distributed seeds of the most wholesome vegetables to encourage raising the right kinds.

To help relieve the distressing obstetrical conditions, we tried to educate both laity and midwife as to the causes and prevention of this ruthless mortality. We called on each midwife to establish friendly relations, and answered all their questions either in person or by letter, and distributed such literature as we had at our disposal. The deliveries conducted were actually demonstrations with explanations of everything done. In answer to an obvious need we created a "maternity Loan Outfit," consisting of bed linen, towels, rubber sheeting, and nail brushes for the midwife's hands. The gratitude of the

committee to which we left this outfit was touching. As one woman said, "It is the first thing that we have ever had"—the first social service equipment to administer to their common needs.

With keen interest we have seen child hygiene develop and spread in our own country, we have helped organize similar work to save the threatened remnant of the children of France, but we have never found greater need nor faced such strange and unique conditions as were presented by those serious faced, stunted little children, who in that isolated dreary North have missed joy and health and youth. Yet never have we worked with greater enthusiasm nor with higher hopes.

"At the Head of the Hollow"

John F. Smith

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Kentucky

THERE is no question before the American people deserving more immediate attention than that relating to the unreached mother and child who dwell in the head of the hollow. In spite of all our social and-welfare work which has yielded such encouraging returns we, who look from the level of the cabin door, know only too well that this work has not reached effectively to the heads of the hollows. Some programs may work well in cities, small towns and villages; some may work well in the lowlands where people are fairly well-to-do, but when these programs are extended to the heads of long, lonesome valleys far back from the common lines of travel most of them break down. Some of us have been watching them break for a number of years, and we are still looking for the movement that will reach out and touch the poor folk who live at the heads of the creeks.

There are hundreds of thousands of people living in such places. They are usually poor. They belong chiefly to that great group of people who though honest, industrious, and frugal, somehow do not possess the knack of getting along in the world. So many elements of failure enter into their lives that it is exceedingly difficult to put the finger on any particular thing and say, "This is the specific cause of this family's misfortune."

But they do live, and not all of them live in the heads of the hollows. They live among the hills and on the plains, high up on the mountain and in the lowlands, live all over the country. A very large percentage do live far up at the head of long, lonesome valleys, where small streams leap over ledges of rugged stone, where wild grape vines form great canopies

over tree-tops, where the mocassin flower, the bloodroot, the gensing, and the maiden-hair fern grow, and where every sight and sound bespeak the great wide out-of-doors. The fragrance of green growing things is ever about them. From their doorways winding trails lead off through bushes and briers, past huge boulders and rippling streams to the valleys below. But in the low country they dwell in marginal places, often far removed from a neighbor's house, and more than many people think dwell within rifle shot of prosperous homes in both town and country where each day brings contacts with those whose daily fare is all that necessity and comfort require.

Why do these mothers live in such remote places?

Partly from choice, and partly because of circumstances which they cannot control. They are usually poor, live from hand to mouth, and thousands of them are ill-mated. Many a husband and father is in ill health, or shiftless, and does not provide well for his family. Many bread-winners have only the poorest means of making a living at hand and cannot forge ahead. A very large percentage, particularly in the South, are victims of pernicious tenant systems which keep their hands at work and their pocketbooks empty.

A very large number of these mothers were born in the wild wood and cling to the shrubbery as the birds cling to the forests. Nature has somehow fashioned them to be the outposts of our present-day civilization, and they play their parts well. They remain by choice to gather up fallen limbs for fuel, to hunt wild nuts which they sell at the country stores, to cook the wild game which their sons and husbands kill, to milk the family cow, work in the garden patch, and rear their children out where nature deals both kindly and severely with little ones. They and their children do the hard first-things which someone must do that the rest of us may have the comforts and luxuries of life.

These mothers love their children as tenderly as do those in more prosperous homes. They often spend days and nights of anguish watching by the bedside of little ones whose cries grow fainter and fainter because no skilled hand is near to render the medical service which is so much needed. Faint and broken-hearted, they often ride in a farm wagon by the side of a little homemade coffin to a lonely graveyard where neighborly hands "put away" a pair of large laughing eyes that continue to glow in the mother's heart until she is brought in another homemade coffin to take her place beside them.

Among the babies that cling to these mothers are many bright spirits with fair round faces and flaxen hair who would grow up to be mighty men of affairs if only they had the chance. Lincoln was one of them. But they often grow into surly men hampered by physical defects which lead to social and

moral defects and disqualify them for the larger duties of life which await them. Girls born with all the exquisite sweetness of the wood thrush's song too often revert to our more primitive ancestors, because a hand is not there to strengthen the arm of the mother as she tries in vain to rear her daughters according to her ideals.

I'm thinking especially of the great army of mothers and the greater army of children whose care is hardest to get, where food is usually the simplest and often least suited to tiny stomachs. These mothers give birth to the purest Americans in our land, and unless some agency grows strong enough to reach them and strengthen their hands this slaughter of our purest American stock which some of us have seen going on for a lifetime will continue.

Why are these mothers classed among the unreached?

The road leading into the hollow is often impassable.

blue eyes and flaxen hair bespeak their Anglo-Saxon blood, dwelling among the hills and lowlands throughout the Southland. Far too many of these are beyond the reach of good schools, good churches, medical skill, and the things that go far towards developing men and women of the larger mould. They live where schools are generally poor, where churches are feeble, where proper medical

First; because of their isolation. Doctors and nurses,—when there are any—usually have headquarters in the county seat. From the county seat to the head of the long, lonesome valleys is often a "long, long trail". Quite frequently it is a very rough way. The road sometimes follows the creek, and the creek sometimes follows the road. The traveler encounters mud, rough spots, high water, no bridges,

and quite often no way around the obstructions. Whoever dares to condemn hastily a country doctor because he does not always answer a far-away call promptly has only to accompany him on stormy winter nights over the kind of roads he sometimes has to travel in order to get the doctor's point of view. Given a poor home without telephone, a desperately sick child afflicted with virulent diphtheria or broncho-pneumonia, fifteen or twenty miles of treacherous road between that child and a doctor who is already overworked, and let the call come on a stormy winter night, and we may easily foretell the issue. Some doctors go; some are too nearly worn out; only the few decline. No one ever needs a capable nurse close at hand more than the poor, isolated mother, and no one in America is farther removed from one.

It is estimated by high authority that fully seventy per cent of the people in the open country do not receive adequate medical care.

Second; because of poverty. The poorest of these mothers do not have even the bare necessities of life. They do not have enough furniture, or kitchen utensils, or clothing. They have no newspapers, almost no books, practically nothing to keep them informed about what the rest of the world is doing. Tens of thousands of them sleep by night in the same clothes they wear by day, the outer garments being removed; so do their husbands and children. The things that add to the joys in the home are often almost entirely lacking.

When the time for a new birth arrives there is no extra room, no extra bed, in extreme cases no extra clothing. Babies are sometimes born in homes where there are no woolen blankets in which to wrap them. In numerous places in every outlying neighborhood births occur with no doctor present, nor is any nurse there to minister to the mother and babe. Only the midwife and a few neighbor women are there. The midwife does the best she can, but she is nearly always untrained and is helpless in a serious emergency.

Quite often the mother is compelled to work up to the very day, frequently to the very hour of confinement. She has had no medical examination, no skilled advice. And when the little one is born she sometimes makes an invalid of herself for life by getting up and going about her work before she is strong enough. Babies must be washed, fed, dressed, put to bed; meals must be cooked and served, dishes must be washed, the house must be kept in order, and the fowls and garden must be cared for —and there is positively no one else to do these things.

Third; because of insufficient food. One must not assume that all poor people set light tables; they do not. But the mothers of whom I am speaking do, as a usual thing, lack proper food for themselves and children during at least a part of each year. Crooked legs,

emaciated little bodies, digestive disturbances, fretful and colicky babies are evidences of this. In hundreds of thousands of poor homes the food supply from the first of February until the middle of May is desperately scanty and uncertain. Corn bread, fat, salt pork, shuck-beans, pickled corn, sauer kraut, half-soured molasses, and black coffee make up the major portion of diet for both parents and children. The mother on limited rations cannot properly nourish her baby, and from this same limited supply it is impossible to prepare a suitable diet for small children. Every health worker of experience knows of many cases where children have been overfed, or fed the wrong kind of food until their digestion is no longer normal. The abundance of milk, butter, eggs, and leafy vegetables is just not to be had under present conditions of farming and gardening and stowing away food for winter.

Corn mill still used in many remote places.

I do not fall out with people who see things in a different light, but my observation extending over many years leads me to conclude that of all the first things which the children of the poor need the very first is a suitable diet properly

served. The dietician who discovers how to prepare this ration from the limited supply of food at the poor mother's disposal will render a service not less than that rendered by the discoverer of the means of preventing diphtheria.

This food question cannot be solved by merely giving instructions to the mothers. There are other elements involved which call for radical changes and improvements in gardening, farming, storing food, cooking and so forth.

Fourth; lack of proper recreation. Of all human beings I have ever met the poor mother at the head of the hollow has my interest and sympathy most. Her time for free recreation may best be expressed by a minus sign. She usually has, or will have, a house full of children. She is with them twenty-four hours in the day, and much of that time she alone is with them. Their cries and shouts are almost never still. She must listen to them by day and by night. Out of six or eight one is almost certain to be ill all the time. She must wash their faces by day and feet by night, make and mend their clothes, care for their wounds, see that they have food and clothing and a place to sleep, and at the same time she must do all her house work including the family washing. She must milk the cow, make the butter, care for the chickens and pigs, work in the garden, and sometimes in the field.

You wonder what the husband does? The division of labor takes him away from the house through the day leaving the wife to do the chores. This is not universally true, but true of more cases than we like to think.

She has no time for play. It is little wonder that she often becomes bundle of nerves, loses her self control, and abuses or neglects her children. Her poverty excludes the possibility of servant's hire, and even if the means were available it is almost impossible to find a girl or woman who would consent to undertake the care of the household where everything and everybody at the best are so badly crowded.

Being a mother at the head of the hollow is no holiday. She usually loses most of her youth early from lack of rest and recreation. Unless some one extends a helping hand she is at the mercy of circumstances, which she cannot possibly control. Choice human diamonds are often found among these mothers, and these diamonds need the polishing which only organized effort can give.

Fifth; lack of adequate educational facilities.

Schools in these remote places are usually of the poorest kind. They are rather generally taught by an untrained man or a young inexperienced girl who has nothing at all to give to the overworked mother and very little for her children. The things she needs most to know as a mother were not taught to her in school, and will not be taught either to her or her children in the schools of today.

Courses of study in graded and high schools were not made for her. The colleges usually pass her by. She is an educational outcast for no school in the land within her reach has the thing she needs most in its course of study. If she is not reached by an outside organization she will have to remain in her isolation from much that is best and most enjoyable and enlightening in life.

This schoolhouse was in use when photographed. Small wonder that education is not popular here.

Sixth; lack of opportunity for spiritual growth.

There are great ministers here and there in the open country, but the majority of those who occupy pulpits at the heads of the hollows are anything but inspiring to their hearers. Many of them are highly emotional. The majority are unlettered. A very large percentage deliver sermons in "gospel song" fashion which kills the finer effect in the minds of most people.

One who has never heard a preacher of the highly emotional type can have little conception of what his preaching is really like. Take the most depressing sermon you ever heard, let it be delivered in shouts and hand-clappings, and gasps, and vocal contortions of most pitiable and dramatic kind,

raise all of its bizarre qualities to the *n*th power, and you will have a sermon comparable to those that hundreds of thousands of people have to listen to when they listen to any at all.

Sermons of this kind have almost nothing to inspire a mother of a large family who gives all of herself and strength to her family. And it is astonishing how frequently one meets with sermons of this type even in these days of progress. It is not necessary to go to the head of the hollow to hear them.

What can be done to reach this mother?

The task is far too large for any one institution or organization. It is a waste of time and money for any one organization to undertake it. Steps to reach her properly involve consideration of questions relating to housing, good roads, cooking, vegetable gardens, storing foods for winter, recreation, education, religion, hours of labor, enforcement of law, infant feeding, general health, other important matters. The organization that ventures to undertake the task alone certainly has faith but evidently lacks information about the bigness of the task before it.

Great progress would be made if the leaders of the organizations interested in the things listed above should meet together and work out a national program of cooperative action in which all would work to accomplish one common task. We have too long been working single-handed at this matter. It would therefore seem wise to me if steps were taken to invite representatives of all the constructive agencies at work in the open country to gather for the purpose of launching a definite nation-wide campaign to reach and care for the millions of marginal people who must ever live under a handicap unless the hand of encouragement and strength is extended to them.

The task is to make the head of every hollow in the land a safe and attractive place for the mothers and children who dwell there. It is a big task, but it is not an impossible one.

Wise Women, or Otherwise

Contrasting Views of The Midwife Problem in Two English Speaking Conferences and Elsewhere

Edited by John Foote, M. D.

TO those who give thought to the problem of finding means to avert the appalling number of infant deaths which occur before, during, or soon after labor, the question as to the influence of the midwife has always been a vexatious one. Communities exist in the United States where the midwife is practically unknown; in other regions, such as the rural south as well as in larger cities such as New York, she is still looked upon as a medico-social necessity. In some parts of Canada she is still called the old French name of "sage-femme"—the wise woman. Her qualifications for practice range from well organized practical training and theoretical instruction tested by examination, as required in New York City, to the no regulation, no education, and no legal supervision of the "plantation practice" of some of the Southern States. The summary of laws to regulate midwifery in the United States prepared by Foote[1] gives some idea of the legal chaos involving the subject amongst us. This much is certain, to all who discuss the midwifery situation—and it has had ample discussion—that although, excepting in the rural south, the midwife is largely an imported functionary and the midwife question is, to a certain extent, an imported question, it is, none the less for that reason, with us for better or worse, and cannot be ignored. This is the view of Dr. S. Josephine Baker,[2] Chief of the Division of Child Hygiene of the Health Department, New York City, who spoke at the Asheville meeting of the American Child Hygiene Association with full knowledge and ripe experience when she said: "There is only one way to solve the midwife problem and that is to face it. Do it. Come out into the open and see who your midwives are, then raise them to such a standard of practice that you will eliminate the incompetent ones automatically.

MIDWIFERY AND INFANT MORTALITY

"The practice of midwives is a question of practical importance and particularly with reference to the reduction of the maternal mortality rates," said Doctor Baker. "Two years ago Doctor Meigs, of the Children's Bureau, in Washington, made a survey of the cities of the United States with regard to their maternal mortality rates. . . . I want to call your attention to the fact

[1] Foote, John, "Legislative Measures Against Infant Mortality," Am. J. Obst., 1919, lxxx, 5.

[2] Transactions American Child Hygiene Association, 1919, x, 83.

that Doctor Meigs reported that every city in the United States that had been investigated showed an increase in its maternal mortality rate during the last ten years except New York City, which showed a decrease of fifty per cent. Now, I do not believe for one minute that the doctors in New York are any better than the doctors of other cities . . . but the only way in which New York City differs from the other cities is that we do require a preliminary education for our midwives. We have a midwife school under city control, with a six months' course, and do not issue licenses to practice to any midwives who are not graduates of that school, or of accredited European schools of equal standing. This is the only essential difference between New York City and other cities, yet the results have been that in all the other cities the maternal mortality rates have gone up, and New York City's has gone down.

"The plain lesson is that you are not going to solve the midwife question by discussing whether or not you are going to solve it. You can solve it only by meeting it. We had three thousand midwives in New York in 1916, while today we have sixteen hundred. In 1907 they reported fifty per cent of our births; today they are reporting thirty-seven per cent. We are eliminating them in the only way I think they can ever be eliminated, that is, by making the standards so high that only the best equipped can possibly remain."

NURSES VERSUS MIDWIVES

Foreign countries have always had a large proportion of births managed by midwives. They have gradually accustomed themselves to the legal supervision and later to the technical training of these "wise women" ever since the thirteenth century when Madam Trotula taught obstetrics in the University of Salerno, and wrote a text book, and became so celebrated as a "wise woman" in the songs of the *troubadours* that even today our nursery rhymes speak of Dame Trot.

There is no possibility here in America of confusing the public health nurse and the midwife, according to Miss Anne Stephens, R.N.,[3] of the New York Maternity Center Association. "I can't see that there is any possibility of confusing the two," she said. ". . . I can't think how they could possibly be confused. How is there anything alike about the nurse and the present type of midwife?" Miss Stephens is in contact with the best midwives in this country—those in New York City—and is certain of her ground. No one could speak more authoritatively. It is all the more interesting to observe that in England the distinction between nurse and midwife is not so marked. What could be a greater novelty amongst us than to have a midwife prepare a paper for discussion at our annual conferences—at a meeting, for instance, of the American Child Hygiene Association? Yet at the National Conference on Infant Welfare, held in London last year, Miss Olive Haydon, formerly sister, York Road Lying-in Hospital, evidently a trained nurse as well as a midwife, said, in introducing her paper—"The

[3] Transactions, American Child Hygiene Association, 1919, x, 85.

work of the Midwives in Relation to Ante-natal and Neo-natal Mortality:"[4]

"It seemed to me that the testimony of the medical profession to the work of midwives as it is today, and to the possibilities of further alterations of our profession in the campaign which is going forward so rapidly, would have more weight than that of a mere midwife. However, I shall try to convince you that the majority of us consistently concentrate on the welfare of mothers and babies, and that many of us are not only alive to our responsibilities and opportunities, but also to our limitations. . . .

THE ENGLISH MIDWIFE

"Midwives not only look to the medical profession for further education, but they look for their support in their efforts to maintain a high professional standard; they wish their relation to the patient respected in much the same way as the relation of the doctor to the patient is respected, and the cooperation of midwives in maternity and child welfare centers is both desirable and desired. This attitude must be borne in mind. To interfere between the midwife and her patient is derogatory to her professional standing and tends to diminish her influence, which may be, and often is, considerable in the prevention of ante- and neo-natal mortality.

"We midwives fully realize that although we may be specialists in the management of normal pregnancies, labours and peurperia, our knowledge is chiefly that gained by elementary study only and by experience; it is not strictly speaking a scientific education. The trained midwife of today has, however, advantages denied to many medical students, training in the practical care of normal pregnancies, labours and peurperia, and the feeding and care of new-born infants. We think that the careful and reasoned observations of an intelligent midwife, and the material she could provide for the pathologist and health workers and the cooperation in nursing treatment, might be factors in the elucidation of the problems confronting the expert in the reduction of the mortality rate, both maternal and foetal, and in the relief of disabilities due to the disease, ignorance and want of good nursing. . . .

"Personally, I think every midwife, when qualified, should practice her profession for at least a year before taking up other work. This would lead to a broader and more sympathetic attitude to those who are practicing midwives. These have their aspirations to add their quota to the common good and only ask to be allowed to work peaceably on professional lines under State control. It would *inter alia* improve the profession, if more educated women would practice, and it certainly would lead to more sympathetic cooperation if other health-workers knew where the midwives' shoes pinch. We are willing to cooperate with those who will cooperate with us. The midwife's duties are well defined in her rules; broadly interpreted and conscientiously carried out they make for a reduction of ante- and neo-natal mortality. To do more efficient work the midwife needs progressive education on broad lines, better economic conditions that will allow her to take fewer cases, and devote full attention to each patient she attends—and a status and consideration commensurate with the importance of her work for maternity and child welfare."

It seems too good to be true that England should have a large number of women trained for this work, of the evident efficiency and vision of Miss Haydon. Yet in Denmark,

[4] Report of the Proceedings of a National Conference on Infant Welfare, held at Kingsway Hall, London, July, 1919, 65-71.

as at the Riget's Hospital, in Copenhagen, where the obstetrical department has a nurse-midwife training-school, the standard of requirements of preliminary education for the young women who study midwifery is as high as that required for nurses in any other department of the hospital. Whatever may be the practice abroad it is quite unlikely that such a system will ever become adaptable to American conditions. To again quote from Foote's [5] report of the legal status of midwifery in the United States which summarizes the opinion of the Sub-committee on Midwife Practice of the Child Welfare Committee, Council of National Defense:

"As will be seen, there is no uniformity of law, or even of required standards. The establishment of competent and reliable teaching centers to educate women in this work seems hardly possible, even if it were desirable. The ideal regulation seems to be that in which the midwife is told many things which she must not do and is placed in the position of a more or less well-trained obstetrical assistant.

"In regulations prescribed by the Commissioner of Health of New York City are perhaps the best midwifery laws now in force. To apply to smaller or rural communities, this set of rules would have to be modified in its details, though not in its essentials.

"Uniform legislation for the enforcement of birth registration and ophthalmia prophylaxis, for proper inspection of the midwife by both the Health and Police Department of the city or state, and for the prohibition of unsupervised obstetrical practice by any midwife, however theoretically qualified, are the minimum essentials in which all state and city laws should have complete uniformity."

OPPOSITE VIEW POINTS

The concrete point of view of the American physician, therefore, seems to be to the effect that the practice of obstetrics is the practice of medicine and surgery, and that the midwife should be abolished by making her unnecessary. This ideal is to be sought by (1) an educational campaign, (2) improved obstetrical teaching, and (3) the provision of adequate maternity facilities in rural communities as well as in large cities. England, in spite of an almost reactionary conservatism in some other matters concerning the rights of the physician, frankly accepts the midwife and, as we have seen, even attempts to educate her in the ideals of child welfare. But this very respect for tradition and established custom—especially concerning an institution so very old and so firmly intrenched as is midwifery—may be the real reason why the midwife is encouraged in England, and the converse may explain why she is scarcely tolerated here. Indeed, certain English authorities go even further, and urge that the same standards of practical training required of midwives, should also be demanded of medical graduates who practice obstetrics! An example of this extreme point of view, which, even granting our inadequate obstetrical medical teach-

[5] Foote, John. Ibid 1.

ing, would unquestionably be resented by physicians if it had been made on this side of the water, is expressed by Dr. Janet Lane-Claypon,[6] of London University, in her recent work, "The Child Welfare Movement." This writer, who, besides being a physician, is Lecturer on Hygiene and Dean of the Household and Social Science Department of King's College for Women, hints at the subjunctive necessity for control by The Midwifery Board of the practice of obstetrics by physicians, when she says:

"A few words are needed upon the subject of midwifery work by doctors. All medical men and women must take a qualifying course in midwifery. After passing the final medical examinations no further experience is required. It is now very widely admitted that the training in midwifery in most medical schools is unsatisfactory and inadequate; that a much higher standard of work is required, and that facilities must be offered for post-graduate work.

"There is no control over the practice of midwifery by the medical profession, and it is therefore all the more important that the work should be of such a character as to render any question of control unnecessary."

In view of the obviously contrasting conditions and conflicting opinions here and abroad, and remembering Doctor Baker's statement that to solve this problem we must "face it," may not our tendency to talk rather than act be due to the same sort of fearsome emotion as that which possessed the breast of the well remembered Color Sergeant in Kipling's Danny Deever? On one point there is found amicable international agreement: whether the midwife is to be encouraged or ignored, true progress will be shown not alone by ability of the populous community to get along without her services, but when that condition is brought about through superior obstetrical facilities in the community and superior obstetrical teaching in the medical school.

[6] "The Child Welfare Movement." Janet Lane-Claypon, London, 1920, 136.

Why Register Births?

"There is hardly a relation of life," says Dr. Frank W. Reilly, "in which the evidence furnished by an accurate registration of births may not prove to be of the greatest value as, for example, in the matter of descent; in the relations of guardians and wards; in disabilities of minors; in the administration of estates, the settlement of insurance and pensions, the requirements of foreign countries concerning residence, marriage and legacies; in marriage in our own country, in voting, and in jury and militia service; in the right to admission and practice in the professions and to many public offices."

Expectant Mothers In Rural Regions

Lottie G. Bigler, M. D.*
Armour, South Dakota

A physician from the city beginning practice in a village and country neighborhood, encounters many problems and difficulties. Many times, I have been discouraged and felt helpless, as there is absolutely no cooperation among physicians in rural communities.

The average rural home is very inadequate for its large family. There is improper sewage disposal, poor water, probably contaminated by sewage.

"NO HELP NEEDED"

I know a family with fifteen children, living in a two-room house. All of these children were born in this house and the only care this mother ever had was what her husband and older children gave her. They were so isolated that even the neighborhood midwife did not get there. During the mother's last pregnancy, as she did not feel as well as usual, she consulted me. I found albuminuria present. I warned her and tried to instruct her. I thought, probably, I had made no impression on her, but she became so worried about herself that she sent her husband to engage me for her confinement. He was rather disgruntled over this new fangled notion of "wanting a doctor." His mother had never had one and she had had fourteen children. His wife was a strong woman, did all of her own work and even helped him in the field. But he was good to his wife and would not be stingy with her and would give her her own way this time. The baby arrived in due time but I wasn't called. When I questioned them as to why, the husband said it was just too far to call a doctor out and the roads were bad and besides, they didn't need any help.

With each succeeding pregnancy, these women work harder, for there is one more to care for, and possibly more hired men to cook for, with no provision for hired help in the house. The usual diet, consisting largely of pork and potatoes, is not what a pregnant woman needs. The butter, cream, and eggs are sold to buy more quarter-sections of land. Among the farmers in the rural districts with which I am acquainted there is no lack of funds. What these people need is to be taught the necessity of using some of their funds for the care of the mothers of this and of the next generation.

According to statistics taken from the rural communities of six different States, eighty per cent of

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the pregnant women have received no advice or instruction during pregnancy. This percentage is even higher in some localities. At least half of the women do not engage a doctor before the last month. Many of those who do so, communicate with the doctor either over the telephone, or by letter. I do not think that the laity are entirely to blame, for many women have told me that when they had asked their doctors if a urinalysis ought not to be made, the doctor said it wasn't necessary. We general practitioners need to be stirred up, for I believe we are all lax in this matter. If we would seize every opportunity, a great deal might be done towards educating our patients.

"ONLY A LITTLE RHEUMATISM"

A case of mine illustrates the ignorance of some of these people. I was called out in the country fourteen miles, over almost impassable roads, to see a foreign woman. The husband had driven several miles to telephone as they had no telephone themselves. He reported that she wasn't very sick—that she had only a little rheumatism in her back. I found her all alone in a two-roomed shack, all but one of the windows boarded up to keep out the winter cold, and incidentally all the fresh air. Two fires were going full blast and the temperature of the room was at least 90 degrees. The woman was lying on the bed. I immediately recognized nephritis with threatened eclampsia. Before I left, the husband returned and I explained his wife's serious condition. He seemed very much surprised to think that this had to happen to his wife, and he liked even less the expense of having a nurse and a housekeeper.

"I VOTE FOR MY WOMAN"

To digress a little, I must tell my suffrage story which illustrates the crass ignorance of some of these people. I was talking to this same man on election day when the Dry, and the Suffrage Amendments were voted upon. I asked him how he voted and he answered:

"I vote 'no saloon,' I no can read so I say to a man there, 'Where I vote "no saloon,"?' He say to me, 'You no want to vote "no saloon"; it makes taxes higher.' I say to him, 'yes I do,' so he show me where to make the cross after 'NO,' so I vote 'no saloon'."

He had in reality voted against the dry amendment. I then asked him how he voted on the suffrage amendment. He said:

"I don't know what you mean by that. I vote 'no saloon' that make woman sufferin'."

I explained to him that Women Suffrage meant to give the women the vote and he then said:

"Ach! the womans don't need to vote, they can stay at home. I vote for my woman."

CARE GIVEN PEDIGREED STOCK

Isolated families, some of which are seventy-miles from a doctor, are the ones who present the greatest problems. Many of them de-

pend on ignorant midwives for their care and instruction. Many women die before a doctor can get to them. Many of these farmers are foreigners. They need help badly and are the hardest to reach for they look with suspicion on any innovations. The mothers often work in the fields up to the last minute performing most arduous tasks. It seems to me that the expectant mother in the barnyard gets far more attention and better care than the one in the house. If the barnyard-mother gets sick the whole household is upset, especially if she be a pedigreed animal. The farmer sends for the best veterinarian, possibly miles away. The State provides free courses of instruction as to how to keep the animals healthy and how to produce the strongest offspring. A man came to engage me to attend his wife who was near term. He said she hadn't been well the whole nine months. I asked him why he hadn't consulted a doctor about her. He said he didn't think there was any need, he supposed they had to feel badly the nine months—she always had during her other pregnancies. In the course of the conversation, he asked me how much I charged. I told him my fee. He said that was ten dollars more than he had paid three years before. I informed him that all fees had been raised. He said he believed he could get it done at the same price he had paid before. He said:

"I would like to have you—you have been recommended so highly, but you can't blame me for saving ten dollars if I can."

I said "No, I can't blame you if you have no choice as to which doctor you call; perhaps it will be all the same to you to get the cheapest."

He said that if he couldn't get it done cheaper, he would be back and engage me. I heard afterwards that he had dickered with an old retired doctor and had finally got him to come for the fee he had paid three years before. I felt like suggesting to him that he advertise for bids, regardless of qualifications. This man owns a half-section of land worth about a hundred and fifty dollars an acre, and his crop this year is worth about six thousand dollars.

A SORDID TRAGEDY

Another example—a man came in to engage me for his wife's confinement. When I questioned him, I found out his wife was not at all well. I suspected nephritis and advised him to bring her in for an examination, or at least, to have a urinalysis made. I never heard from them until about the end of term and then I got an urgent call. I found her in convulsions and delivered the baby. The mother died soon after delivery, and it was with difficulty the baby was saved. The husband couldn't be made to see how "these new ideas" might have prevented the mother's death. He thought it was the doctor's modern method of profiteering. He

also remarked he was sorry to lose his wife, as she was a good cook, and could milk more cows than he could.

BABY CLOTHES

I wish the mothers could be instructed on making layettes. Many times the infant arrives with very little, if any, provision made for clothing. The mothers argue that if the baby lives, they can get things at the store. So many seem to expect the babies to die at birth, or to be still-born. The percentage of deaths is high and I think this is due largely to the fact that they expect it to be so, and do not do the things necessary to prevent infant mortality. Those who do provide a sufficient quantity of clothing, do not use the proper materials. I have seen one outfit after another without a thread of wool in any of the garments. Wool is very necessary in a layette.

THE UNMARRIED MOTHER

No small part of the problems in rural communities, is that of the unmarried expectant mother. Sometimes it seems that illegitimacy is on the increase. During my first six months in the community where I am practicing, eight girls came to me pregnant from two to eight months. I suppose more come to me than to the other physicians because women in the profession are scarce in this State. They probably think a woman will be more apt to help them out of their difficulty. I have succeeded in talking many of these girls into choosing the honorable path. If only more could be reached, many tragedies might be averted.

SOLVING THE RURAL PROBLEM

No doubt, these problems of expectant mothers in rural communities have to be approached in different ways, in different communities. The crying need is for nurses trained for rural work. The average nurse, born and raised in the city, is unable to adapt herself to rural conditions. One nurse for a county is insufficient. There should be enough nurses so that all homes could be visited and individual instruction given. Health centers and free clinics should be organized with the school house as a meeting place. Sterile supplies should be provided at cost. The school teacher could give some instruction if she were capable. We must have better public health inspection in the rural homes. Here, often by chance, we discover contagious diseases raging with no effort made at isolation of the sick and in most cases, it is not even reported. By special legislation, we might accomplish much. The Sheppard-Towner Bill may help solve these problems effectively. At least, it would do much to protect the prospective mother and her infant. We must face these problems squarely and do all in our power to give the expectant mother and the unborn infant the best possible chance.

The Unmarried Mother
Before and After Confinement

Foster S. Kellogg, M. D.*
Boston

THE problem of illegitimacy is so large and many sided that we may as well admit in the beginning that all agencies other than the state or central government are in a measure inadequate for its solution. Scandinavian countries and France recognize the truth of this: each attempts a state solution according to its temperament and point of view. In Scandinavian countries, paternity established, the child is essentially legitimized and its father must support it until it can earn a living. In France, if a child is illegitimate, it is not even legal to declare its father without his permission, but the state, if necessary or wise, becomes its adopted father and sees that it is reared in the country without want, and under state (official) supervision, and is taught a trade, as the legitimate child of its foster parents. We have not the frank view point either of the one—that a man's responsibility for his children includes, under all circumstances, his illegitimate as well as legitimate children, or of the other one—that the state must protect the blood integrity of each family to the extent of itself assuming the fatherhood of illegitimate children. It is interesting to note how each system reflects each country in many ways —but most strikingly in relation to woman's position in that country—for Scandinavia gave birth to the "new woman," while France is still a stronghold of the "old woman." Each recognizes frankly that illegitimacy exists as a state proposition and would feel that our attitude—on the whole that it is an occasional accident fit for private charity and not of state importance —is a hypocritical one. However, we have not the continental point of view or the Scandinavian one either, nor is it proven that we should have, nor, probably, would their methods work with us. None the less, our solution worked out in accordance with our temperament lies probably with the state, at least in part—certainly it lies in the future, though illegitimacy has been studied here for many years.

ONE GENERATION'S ILLEGITIMATES

I have just referred to the bigness of the problem and I would impress this further with a few figures from Massachusetts. In a few years prior to the war, from four to five per cent of all registered births in Boston were illegitimate, in round numbers eight hundred and fifty births a year. In the

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same year, two and half per cent of births registered in the state were registered as illegitimates, over two thousand births a year. These figures, are, of course, smaller than the truth. In a twenty-year generation then, we have born in this state—and these figures show it is a state-wide problem, not a local one, especially as many of the Boston births are of outside Boston residence—between forty and fifty thousand illegitimate children, at the least, with the probability that a correct figure is sixty or sixty-five thousand.

THE PENALTY OF SEPARATION

These children are economically worth to the state one hundred million dollars plus, if they become good citizens; if they become bad ones, besides the loss of the one hundred million, they become a state expense along the routes of insanity, criminality, prostitution, and so forth, to an unguessable amount—and it is fair to assume that the neglected child born out of wedlock has less incentive to do right than the child of any other class. It is obvious that prostitution, criminality and venereal diseases are recruited from neglected women who have had illegitimate children. The infant mortality rate for 1914 for children born in wedlock was ninety-five. The infant mortality rate in 1914 for children born out of wedlock was two hundred and eighty-one, three times as great. This means that between one-quarter and one-third of the infants born out of wedlock die before they reach one year of age. This represents so much economic waste. The chief cause of this high infant mortality rate is separation of baby and mother.

The number of deaths under one month, per thousand illegitimate births, was two times as high as legitimate births; at one month it was eight times as high; at two months six times as high. This difference was most noticeable; the death rate from gastrointestinal disease was six times as great in illegitimate babies. These figures show the seriousness of the state-wide problem of illegitimacy.

SIN OR PROBLEM?

The first step in progress in the solution of the problem of illegitimacy in America depends on a reconciliation of two opposite or at least differing points of view. For lack of better terms these may be called the "Orthodox" and the "Social Service" points of view. It is not worth the space to trace the growth of these in the fields of illegitimacy, but it is apparent to any outsider touching the work that they exist—that they conflict—and that because they conflict they hinder progress. It is equally apparent that the "Orthodox" point of view sees illegitimacy in terms of *Sin* and that the "Social Service" point of view sees illegitimacy in terms of *Problem*. To the ordinary person of today, there is little to choose between listening to an exhortation before a gathering of

illegitimately pregnant women on original sin and eternal damnation and reading the wordy "patter" of some professional social service investigator on the "key-concept" to be unearthed in studying case records. Both seem equidistant from tangible results and on the whole their past show that they are. The "Orthodox" point of view wishes soul salvation; the "Social Service" point of view seeks economic salvation—and the one is apt to criticise the other's work for putting stress on its own feeling in the matter. This hinders progress. They should realize that they are working for the same end and get together. It is hard for me to see that either is entirely right—saving a woman's soul may make her economically efficient, or at least willing to become economically efficient, or it may not; making a woman economically efficient may make a woman save her soul, or willing to save her soul, or it may not; but, and I believe that this is the crux of the situation, before you can save her soul or make her economically efficient, or both, you must discharge her after the birth of her baby only after such care and after such time that she may be self-supporting at work.

We may epitomize this one big outstanding fact by saying that, while it may be no economic importance if a woman with a husband to support her and her child is left in poor shape after childbirth, it is the sine qua non for her economic salvation that the mother with no husband to support her and her child must be discharged in the most perfect health she has ever enjoyed. That she shall have faith and religion either restored or inculcated, if possible, is highly desirable; that she be helped economically and studied as a problem is also highly desirable—and I do not see that these necessarily conflict—but that she enjoys perfect health to work is essential.

We next consider how to obtain this result under present conditions and with present existing facilities without taking the long and difficult step to complete State control.

RECORD OF MATERNITY HOMES

Passing by the use of boarding out in the carefully investigated family—except for the individual "exceptional case"—since because of its diffuseness this system obviously cannot attain the desired result, as becomes clearer when we see how much time must be used to attain it; and overlooking the "occasional case" where the girl's family wish to keep her at home and shelter and provide for her, we find Maternity Homes. By keeping these at a high level of staff—superintendent, teachers, doctors and nurses, and social service—we may obtain satisfactory results.

Let us consider the arguments in favor of the use of the present homes: (1) The practical reason that they exist and would be difficult to get rid of, especially as they believe firmly in themselves and

represent a large monetary investment; (2) that only in small institutions is it possible to get home atmosphere and personal contact with the Home mother and her assistants; (3) that they are relatively efficient. (a) Of the 847 infants of illegitimate parents in Boston, 49 per cent were born in hospitals, 25 per cent in maternity homes, 3 per cent in the public infirmaries, 23 per cent in private homes. Agency or death records show that 230 of 847, 27 per cent, had died before they were a year old. Of the infants born in private homes 24 per cent were known to have died; of those born in hospitals, 35 per cent; *of those born in maternity homes and the public infirmary, only 17 per cent.* (b) In the maternity home with which I am connected, 425 consecutive mothers, from 1914 to date, have been confined without a maternal death. In this time twenty-five babies died, a rate under 6 per cent. Of these ten were premature. Only one case in six years died of gastrointestinal disease. The average stay, post partum, in the institution was ten weeks, so that while this death rate is not directly comparable, it does cover the first two or three months after birth.

The advantage of such Maternity Home care over that in the selected private home is that the woman and baby get two, three, or four months good pre-natal care, the best possible hospital care in labor, and the best post-partum care, so that the mother is sent out—and this is fact, not theory, because she can go only on the physician's say that she is fit to work—in such a state of health that she can support her child, and this is in the last word, what her salvation and economic worth depends on.

THE STAFF OF A MATERNITY HOME

To accomplish this properly, it requires the following staff: first, trained obstetricians and hospital facilities (for we have handled contracted pelvis, adherent placenta, toxaemia of pregnancy, with or without convulsions, haemorrhagic disease of the new-born, and so forth; and in this series we have made our own necessary repair work, cleaned up tubes, and done other necessary pelvic and general surgery); it takes a trained pediatrician for the babies; it takes a dental staff, an internist, a surgeon, an eye, nose and throat man, and a neurologist as available consultants. It is hard to see how this can be reproduced for illegitimates except in a Maternity Home.

I have outlined this in some detail to show not only the high degree of efficiency it is possible to obtain, at least medico-sociologically, in the existing agencies, but to back my contention that unless the maternity homes can and will show a good record of accomplishment they should cease to receive support, because a staff of high grade can be obtained for all of them. These results were obtained in a home originally and still fun-

damentally of the Orthodox type, but in which there is hearty accord between the trustees, superintendent, and the medical staff, and in which each group tends strictly to its own business, and in its own department is supreme; in a home inadequate to care for the various illegitimates it should care for, and to give its patients the exercise in the fresh air they should have, as it is in a crowded, poor part of the city. Incidentally, the staff is sufficiently large so that each man gives but a little time in a year to the work and every man of the staff holds one or more, so to speak, major staff positions in bigger hospitals.

THE IDEAL HOME

In an ideal Home we should get better results with gardens and outdoor porches, and better facilities for handling babies, with a distinct house for caring for venereal pregnant illegitimates and a syphilographer added to the staff; with a bit more breadth of social service and a greater individualization and mental study of each case by the neurologist working with the Social Service, with a view to placing it most favorably; with a wider publicity, and a carefully individualized study of the adoption question, with rooms to take back mothers and babies after discharge —for illness or rest, or during temporary unemployment while placing in better or different work, so that each mother would turn to us in trouble as to her real home—we should obtain results satisfactory for the country if such places were run in each community where needed. Further, we must evolve some system of grading and typing illegitimates before we start work with them, so that we do not fritter away the high cost on useless material and contaminate the hopeful individuals with the hopeless.

A STATE CLEARING HOUSE

The sanest solution to this end is to establish a State Clearing House or State Board for Illegitimacy.

This raises the question why, if maternity homes may be made to give good results, should there be a State Clearing House for Illegitimacy? Chiefly because there is little intelligence or rather little knowledge, and that not coordinated, on which to base intelligence, shown in the distribution of types of illegitimacy. The different agencies each have an idea of the type it works best with. A clearing house for distribution purposes would give them that type, but chiefly a clearing house would sort out the mentally deficient. The mentally deficient illegitimate gets in everywhere. She is said to be from 40 per cent to 60 per cent of all illegitimates. She is a menace and a useless expense because caring well for high grade illegitimates is very expensive. She should be sorted out and put where she has no opportunity to repeat. This a clearing house with a primary mental examination would

do, and certain existing agencies could handle these cases. Also, take the question of venereal diseased illegitimates. These represent 8 per cent or more of Boston illegitimates. Venereal disease is an accident of luck accompanying illegitimacy. There is no valid reason for making it a distinction against good care, rather the reverse. Yet as matters now stand, the woman unlucky enough to be infected must go to a less desirable place than one who is merely illegitimately pregnant. The clearing house would see to them through some designated, existing agency. There are certain types, as the very young and the very wilful, who are better cared for in private homes than in maternity homes, both for themselves and for the institutions. These the clearing house would see to through existing agencies which are familiar with this type of case, such as Children's Aid Societies.

This clearing house must of necessity be composed of representatives of each agency in so far as the placing of the case goes in the beginning, except that certain types like the feeble-minded and venereal cases will go directly to designated agencies. Only by this method will you prevent the jealousies of different institutions coming in. Placed from this clearing house, the report on each case, followed for one year if possible with the end result, must come back from each agency for compilation and study. In five or ten years this accumulated data will have sorted the women into different types and will show what types are best handled in each way. In this way only can progress be made in the study of this great economic problem, and advance made. Only in this way can we study prophylaxis of illegitimacy.

CONCLUSIONS

1. That illegitimacy is a State problem.

2. That at present little or no progress is being made with the problem in this country.

3. That the best form of care for high grade illegitimates requiring care outside their own homes—with a few exceptions—under present conditions, is the well equipped, well staffed Maternity Home.

4. That the worst form of care under present conditions for illegitimates—with a few exceptions—is a public lying-in hospital or maternity wards in public or semi-public general hospitals, because they are usually taken in only in labor and put out too soon.

5. That the best form of care for low grade illegitimates—with a few exceptions—under present conditions is the State institution.

6. That the medical and social service standing of the Maternity Homes be kept to as high a degree of efficiency as possible under State Board of Illegitimacy supervision.

7. That the chief reason for no progress is lack of an adequate machinery for sorting, distributing

and recording of end results, and for coordinating effort, expense and information.

8. That such machinery may be obtained from a central clearing house composed of a representative of each agency, under the directorship of a long-time chairman, with the physicians, social workers, and clerks necessary.

9. That the cost of such a board should be supplied by the agencies interested, including the Commonwealth.

10. That in addition to the fact that a clearing center would reserve only the worth-while-working-over women for the more expensively run agencies, it would be of equal or greater use economically in early segregation, and early getting under observation a large number of mentally deficient whose first tangible evidence of their mental condition is pregnancy.

11. That the problem of illegitimacy is big enough to be handled and should be handled as an entity—directed legally, sociologically, and medically—loosely at first until knowledge is accumulated—under one office; that any legislation, as for example, a proposed Maternity Pension Bill, should not include clauses concerning illegitimacy because it will increase the present too great decentralization and so add to the present confusion.

The Puppet Show As a Health Teacher

Walter Storey

PUPPET shows of many forms have followed man in his upward march of progress from his most primitive days. Always with him, they have been both his toys and his teachers. Ancient Egypt and India had their puppet shows, Greece and Rome knew these pleasant entertainers. Some of the puppet shows were religious in character, but most of them were as they are today, playthings of the race.

Out of the war, from which so many things have come, both good and bad, has come this old-new toy as an aid to health instruction. During the American Red Cross Child Welfare Exhibit in Lyons, France, (where, curiously, Guignol, the Punch of the French puppet show is said to have been created,) the audiences were entertained and instructed in ways of health by this, their own peculiarly French form of amusement. Here French children and their fathers and their mothers saw Poninchinelle, La Mere Gigogne, and the droll and much loved Guignol, whose name is also used to designate the puppet show itself. Day after day the little puppet actors gave, in dramatic form, a story in which a poilu insists, after an amusing and almost disastrous experience, that the mother

Courtesy of American Red Cross

The French Punch and Judy Show.

should herself nurse the baby. "Guignol as a Nurse", was the delightful title of this show.

Mr. Philip Platt, who organized the Lyons Child Welfare Exhibit, first saw in this French puppet theater the possibilities of linking together its dramatic interest with health instruction. The French, old and young, stood in long queues wating for a chance to see Guignol as shown by "La Croix-Rouge Americaine".

In construction the French puppet show is a simple affair. High on the side of a cloth covered booth, gay with a design in gold and color, is a small opening—the stage. This is far enough from the ground to allow the showmen to hold their hands above their heads with a puppet on each hand. The showman's thumb and second finger are inserted inside the sleeves of the puppet, while his first finger makes its head move in life-like twists and nods. One or more of the troupe, who are always artists, speak for the puppets, changing the voice to suit the character.

THE MARIONETTE

In this country several attempts have been made recently to use another form of puppet show—the marionette, in health propaganda. The National Tuberculosis Association has developed through Mr. Mathurin M. Dondo, a New York artist, a marionette show that endeavors to overcome through ease

of operation the chief obstacle to amateur productions. Mr. Dondo has invented a set of papier mache puppets and a collapsible booth and stage with which a novice, with a little practice, may produce a creditable and interesting performance. The Italian marionettes, unlike the Guignol puppets, are operated from above with wires and strings. Mr. Dondo has simplified this method, which calls for considerable skill, and has devised a simpler system of wires which a child may operate. The cost of a complete outfit, it is stated, is not much more than the price of a motion picture film, a thousand feet in length.

ANOTHER TYPE OF PUPPET

Another interesting effort to dramatize health by means of the puppet show has been made by Miss Stella Boothe, R.N., of Seattle. She has given performances, before many school children, of a health playlet written by herself with a stage and puppets of her own design. Her puppet show resembles more closely the ordinary theatrical stage than either the Guignol or Mr. Dondo's marionettes. Delightfully designed cardboard actors, six or seven inches high, move on and off the miniature stage, manipulated from the left wing by strings. While Miss Boothe's creations, "Fresh Air", "Closed Windows" and the other creatures of her fertile and dramatic imagination cannot move their hands and feet as can the French Guignol and the Italian marionettes, they represent dramatically and with child-like simplicity health facts which more learned grown-ups have heretofore had to get in less interesting ways.

The backgrounds, or "drops", as they are termed in the theater, are another attractive feature of Miss Boothe's puppet show. Each episode in the little drama has its own scene, which may be quickly changed, in front of which her fantastic and altogether charming characters play their parts.

This little puppet show is operated by a trained puppetteer, while an explainer in front tells the story to the children. Miss Boothe's method is a combination of delightful story telling and interesting stage pictures.

INTEREST—THE CRITERION

Undoubtedly the puppet show will be a recognized form of health propaganda. All of us who are interested in methods of spreading health information recognize the great and first obstacle to any form of propaganda. And that is to get people to read the pamphlet, to come to the illustrated lecture, to visit the exhibit. They ask themselves first, "Is it interesting?" The puppet show has already overcome that obstacle even for grown-ups. We are all children after all, and we do not need to be told of the allurement of action, of drama, of colorful stage pictures, perhaps of humorous touches, and above all, of make believe that is wrapped up in this race-old toy, the puppet show.

Health Provisions for State Laws Relating to Children

ON the seventh of January, 1921, the Advisory Committee of the National Child Health Council presented a report on "Health Provisions for Laws Relating to Children." Children's Code Commissions are meeting or reporting in a number of States, and health provisions have received little attention in the past in laws relating to children.

The first task of the National Child Health Council* was to work out plans for coordinating the activities of its members, and for relating them to the plans of others.

The next step was the formation of national advisory committees to meet the increasing demand for authoritative opinions on problems related to child health and child welfare.

The National Child Labor Committee, a member of the Council, pointed out the urgent need for information as to health provisions in laws relating to children. The committee appointed to report on this matter has as its chairman Courtenay Dinwiddie, the Executive Secretary of the National Child Health Council; the other members being, Richard A. Bolt, M.D. American Child Hygiene Association; E. Dana Caulkins, National Physical Education Service; Taliaferro Clark, M.D., U. S. Public Health Service; Edward N. Clopper, National Child Labor Committee; Anna E. Rude, M.D., Children's Bureau; Willard S. Small, Ph.D., Bureau of Education, and the secretary, James A. Tobey, American Red Cross.

OUTLINE OF SUGGESTED HEALTH PROVISIONS FOR STATE LAWS RELATING TO CHILDREN

Inasmuch as health is of paramount importance to child life and as it has often received minor consideration in State Children's Codes, the Committee on Health Provisions for Laws Relating to Children wishes to emphasize the need for adequate treatment of this subject by all States. The following are points which should be borne in mind.

PRE-NATAL CARE

1-A—State Children's Code Commissions should recommend the removal of all legislative restrictions which prevent proper and complete measures for pre-natal and maternity care, and the granting of positive legislative authority for undertaking and promoting such meas-

* MOTHER AND CHILD, 1920, i, 2, 90; and i, 4, 175.

ures. (Note: Examples of legislative restrictions that should be removed are such limitations as to tax rates or levies as make it impossible to provide adequate appropriations for the care of the health of mothers and children. Also in some States local authorities are not permitted to undertake certain important measures unless these are specifically authorized by statute. Such general legislative restrictions which prevent necessary health measures are apt to be overlooked in drafting health and welfare legislation.) Facilities for the education of expectant mothers, for the establishment of pre-natal health centers and clinics, for the protection of expectant mothers in industry, and for the health supervision of mothers, should be definitely authorized by law.

CARE AT BIRTH

A—Midwives.

State laws should require that all midwives be licensed by the State Health Department for the purpose of permitting only those who are properly qualified, to practice midwifery, and that adequate provision be made for proper supervision by state or local health authorities of all such midwives, to see that they observe all regulations, subject to revocation of their licenses. Educational training for obstetrical attendants and midwives should be authorized only where the facilities for training are adequate and there is proper educational and health supervision.

B—Control of Ophthalmia Neonatorum ("Babies Sore Eyes").

Every State Health Department should be specifically authorized by law to require the immediate reporting of all inflammatory conditions of the eyes of the new born, to require treatment of the eyes of the new born at birth, and to furnish the prophylactic for this purpose, for the prevention of blindness. (Note: Experience has shown that the law should describe this disease rather than simply refer to it by its technical names.)

C—Vital Statistics.

The law should require the prompt reporting of births by the professional attendant to local registrars of vital statistics not later than three (3) days after birth. Registrars should be under the health department. Legislation requiring the reporting of still births is important.

D—Supervision of Maternity Homes.

All institutions in which mothers are given care during or near confinement should be licensed, subject to the periodic inspection and approval of health authorities.

INFANT AND PRE-SCHOOL CARE

A—Legislative restrictions should be removed and definite legislative authority granted so that

adequate facilities for protecting and promoting the health of infants from birth to the beginning of school age can be provided by state and local authorities. (Note: The type of legislation necessary for this purpose, with reference to babies, pre-school children and mothers, is indicated under the paragraph 1-A, which deals with the pre-natal period.)

B—Control of Milk and Milk Products.

There should be legislation requiring the general pasteurization of uncertified milk, the supervision of such pasteurization, and such other regulation and supervision of the production, handling and preservation of milk and milk products as will insure a safe supply.

CARE OF CHILDREN IN SCHOOL

A—Health Education.

There should be legislation providing for the instruction and training of all children of school age, for the purpose of developing health habits through supervised physical activities, free play, and practical instruction in hygiene, including personal hygiene, nutrition and sanitation.

Adequate provision should be made for the promotion of health education by the states in cooperation with local communities.

Provision should be made for the instruction and training of all teachers in the fundamental principles of health education.

(Note: Such legislation should allow scope for the development of initiative, spontaneity and responsibility on the part of the child. Rigid and uniform courses of physical drill or of hygienic instruction should not be prescribed, but rather there should be the normal stimulation of the child's physical development and the inter-weaving of health education into all the many subjects of which it naturally forms a part.)

B—Physical Examinations and Health Supervision.

There should be State legislation making it possible for counties, municipalities and townships to provide facilities for periodic physical examinations and for promoting the health of school children. The appropriate State authorities should be authorized to promote the development of such facilities. (Note: The type of legislation necessary for this purpose is indicated under Paragraph 1-A.)

It should be required that the health supervision of school children be closely correlated with the health supervision of babies and pre-school children.

C—Health Classes for Special Groups.

Legislation should authorize facilities for the training and instruction of special groups which, by reason of disabilities, are unable to receive adequate education

and health supervision in the regular classes.

D—Sanitation of School Houses and Their Environment.

School buildings, school grounds and accessories should be regularly inspected and supervised as to sanitary conditions, subject to the regulations and jurisdiction of the health authorities.

CHILDREN IN INDUSTRY

A—Physical Supervision and Health Education.

As long as a child is of school age he should receive health education and supervision. (Note: Experience shows that the continuation school offers an effective medium of health education and supervision.) Physical examinations should be given when he leaves school to go to work, at each change of occupation, and periodically thereafter while he is of school age.

GENERAL

A—Administration.

In each state there should be a bureau of child hygiene. The administration of all legislative provisions affecting the health of children, except those which properly pertain to other state agencies, should be vested in this bureau. The work of such other agencies and that of the bureau of child hygiene should be properly coordinated.

B—Control of Institutions and Agencies.

All public and private institutions, agencies, courts, and boarding homes caring for dependent, defective or delinquent children should be required by law to have adequate health supervision over their work and wards, subject to the regulations of the health authorities.

All measures dealing with the appropriation and expenditure of funds for material relief in connection with child or maternity care should specifically make provision for adequate care of the health.

REFERENCES ON CHILD HEALTH AND CHILD WELFARE LEGISLATION

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National Health Council

A NATIONAL Health Council was created in Washington on December 10, 1920.

This Council was the outgrowth of efforts initiated by the American Public Health Association, the American Medical Association, and other agencies, in past years, to coordinate national voluntary health organizations. These efforts culminated in a special investigation conducted by Dr. D. B. Armstrong during the summer of 1920, under the direction of Dr. Charles J. Hatfield, Dr. Watson Rankin, and Dr. Livingston Farrand, with the financial aid of the American Red Cross.

The Council approved of the following list of activities as indicating the legitimate field in which it might function:

1. A special information bureau.
2. A legislative bureau.
3. The coordination of health activities.
4. Periodic joint conferences.
5. A statistical bureau.
6. The development of educational health material.

The membership of the Council at present includes the following nine organizations: the American Public Health Association, the American Red Cross, the American Social Hygiene Association, the Council of State and Provincial Health Authorities, the Council on Health and Public Instruction of the American Medical Association, the National Child Health Council, the National Committee for Mental Hygiene, the National Organization for Public Health Nursing, and the National Tuberculosis Association.

The officers recently elected are: Chairman, Dr. Livingston Farrand; Vice-Chairman, Dr. Lee K. Frankel; Recording Secretary, Dr. C. St. Clair Drake. The election of a treasurer was deferred until further consideration could be given to the whole question of financing the project.

The by-laws provided that "other national health organizations may hereafter be elected to membership by two-thirds vote of the members". Provision is aiso made for advisory or conferring, as well as directly participating members. The International Health Board probably will, together with official agencies such as the United States Public Health Service, be associated with the Council in this capacity.

The Public Health Council, representing as it does many prominent national health agencies, should serve as a valuable clearing-house and coordinating center, in many fields where common functions are performed. It aims to be an integrating force among independent, autonomous agencies, rather than a merger of such agencies into one organization. It should increase the economy and effectiveness of operation, eliminate duplication of effort, and enhance opportunities for sympathetic and constructive public service.

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FEBRUARY, 1921

A Drive for Child Health

DURING the war period the young men of our Nation were submitted to a careful and thorough physical examination by the various draft boards. They were weighed in the balance of physical fitness and found wanting. One out of every two examined had some physical defect. One out of every three was so incapacitated that he was rejected and deprived of the honor of serving his country in its time of need and peril.

These young men were in the period of their greatest strength and vigor and yet one-half were handicapped by physical defects that could have been prevented and avoided if the factors which produced them had been controlled in early childhood. The medical profession should not be called to account because such a condition was found to exist for the work of the physician in the past was devoted solely to curing the sick. Today a broader vision has appeared and many doctors are realizing that their greatest duty and opportunity is to keep people well. To accomplish this we must secure conditions which will provide, promote, and protect health.

A stream is no purer than its source, and to improve the race we must purify and dignify motherhood and babyhood. John Burns, in an address before the English Speaking Conference on Infant Mortality in London, in 1913, used this couplet to describe how we could improve the coming generation:

"The parents should be cleanly wed
The children nobly bred, wisely fed, and firmly led."

Healthy babyhood is essential for sturdy manhood. No one can deny a child the right to be born healthy and sound and have a chance to live. Intelligent advice and adequate care should be made available to the mother before the baby is born, and she should receive skilled assistance at the time of birth. The advantages of breast milk should be emphasized. The little toddler must have intelligent care and health supervision. His diet and manner of feeding should

be closely watched and early physical defects must be detected and remedied before they progress too far, and before he enters school. His teeth should have attention and dental caries prevented by proper diet and oral hygiene. Decayed teeth poison the entire body and ruin the digestion. They cause malnutrition by poor assimilation of the food from incomplete mastication and many essential foods cannot be chewed. Dental service should be provided for needy children. When the child reaches school age he should receive thorough periodic physical examinations and all defects found should be remedied before they bring about results which would make him physically unfit. Enlarged tonsils and adenoids harbor disease germs which poison the body, and they also mechanically interfere with proper breathing. The city of Rochester, in New York State, established a municipal clinic for the removal of adenoids and tonsils, and as a result of a "tonsil-adenoid" drive over two thousand children were operated upon in the summer of 1920 without a single casualty. Children should receive physical training and education in health matters in the schools just as they receive mental education in order to instill correct health habits in their minds. The Education Department in New York State recognizes this and has authorized the employment of trained nurses as health instructors on the same basis and pay as the other teachers.

If the child enters the fields of industry and labor, he must be protected from improper conditions and surroundings which would render him physically unfit for his life work.

These are but a few of the ways in which we can improve the health of the coming generation. Let us profit from past experience or rather inexperience, and make amends for the neglect of our children. Everyone would like to be able to do something for children. Many are prevented by lack of time, experience, and money. The American Child Hygiene Association was organized to carry on this work and it has the time, the experience, and a tremendous opportunity. There undoubtedly are thousands of persons in this country who would gladly and willingly become identified with a movement to raise the standards of health and physical well-being of our boys and girls. They will not know of the American Child Hygiene Association and its program unless they are told, and it should be the duty and privilege of every member to extend the usefulness and influence of the Association by urging their friends and associates to join it.

—Henry L. K. Shaw.

President of the American Child Hygiene Association

The Foreign Field

Child Welfare Units in Europe

DR. Livingston Farrand, Chairman of the Central Committee of the American Red cross, under date of January 10, 1921, writes:

"Announcement was made several weeks ago of a change of policy regarding work of the American Red Cross in Europe. The original intention was to complete the relief work that was involved in the obligations resting on the organization in consequence of the war, believing it then would be possible to withdraw entirely from the foreign field, except insofar as it might be necessary to meet special emergencies. A later survey, however, showed the pressing importance of the child welfare problem in certain European countries and accordingly the Executive Committee of the American Red Cross, in cooperation with the general Commission to Europe, with headquarters in Paris, outlined plans for contracting and terminating the general relief work in various countries and the establishing of small units to deal with specific work with children, which had an irresistible appeal. To provide for the initiation of this work the Executive Committee voted an appropriation of $5,000,000 from the reserve fund of the Society. The Red Cross is also participating in the united appeal of the European Relief Council, now under way, to provide funds for the extension of the work, in connection with that of the other organizations composing the Council.

"I am now able to announce that the new policy has become effective; that the process of making the shift from the general relief basis to the child welfare unit system is being expedited with greater dispatch than was anticipated, in view of the many problems of organization which arise in connection with such a radical change; and that substantial progress has been made in setting up the units which are henceforth to represent the chief Red Cross work in Europe.

"Nearly twenty units are already at work, three of which are located in Montenegro and most of the others in Poland. Within a few months it is expected that fifty units will be in full operation and that at least a hundred will be established ultimately, that being the minimum number estimated as necessary to cover the widely scattered territory, although still more may operate effectively if resources permit. Plans for child welfare work embrace the countries already noted, the Baltic states and to a certain extent Austria and Hungary. In Austria the medical situation, so far as doctors and hospitals, are concerned, needs little aid from

the outside, and the Red Cross assistance there will be mainly in meeting shortage of medical supplies required in the treatment of children. In Hungary the situation is much the same. The field for greatest concentration of our effort is in Poland and adjacent countries and in Jugo-Slavia.

"It should be distinctly borne in mind that the work which the American Red Cross aims specially to carry on is in the interest of children who require medical care. This work should not be confused with that of feeding several millions of children who are not afflicted by disease but who are threatened with starvation. The general feeding problem with respect to children in Europe is to be met by the American Relief Administration and other organizations embraced in the European Relief Council. The American Red Cross, of course, is vitally interested in seeing this relief work made effective, but as an organization its efforts will be directed to the medical and nursing needs; such incidental relief work as it performs will be that necessary to supplement or assist its particular objective.

"In this connection it should also be kept in mind that it is impossible to carry out the program of medical and nursing care without administering some relief of other kinds. Food and clothing may be an essential complement to medical service; and then again the child help frequently and of necessity implies help for mothers. In all cases the Red Cross effort is directed toward building up in the community, in connection with the public authorities and local organizations and representatives, permanent, constructive measures for child welfare which will remain when the Red Cross withdraws. Through the visiting nurses and other agencies special attention will be placed on the educational aspects of the problem.

"The general plan of organizing units provides for a doctor, several nurses and a trained social worker to each unit. Wherever possible local personnel will be utilized. It is impossible, however, to set up an absolutely uniform standard, as the needs of one country or section may be wholly different from those of another. In changing from the old organization to the new, Red Cross personnel now in Europe will be adapted, so far as possible, to the requirements of the new policy. It will be necessary to add to the personnel from this country to some extent, especially as to doctors, and these will be carefully selected for their fitness and experience in dealing with the care of children.

"One of the most difficult problems incident to the change of Red Cross policy has had to do with the disposition of supplies which have been stored for general relief purposes. To whatever extent possible these supplies will be made available for use in connection with

the child program; as to supplies in general, arrangements are being made by the European Commission for their distribution in the most practicable ways.

"The Junior Red Cross will continue to carry on its distinctive work in behalf of the children of Europe, in accordance with the program launched soon after the signing of the armistice. This work, while coordinated with, is not included in that which has been described above."—[The Red Cross Bulletin, 1920, v, 2.]

Greece

School Hygiene

The Greek Ministry of Public Education reports that the Medical Department of the Ministry of Public Education has established courses of hygiene in all normal and secondary schools, as well as in upper normal schools. For use in these courses sixteen books and pamphlets, dealing with hygiene, have already been published.

SCHOOL HYGIENE ORGANIZATIONS

School kitchens have been opened in Athens, Patras, Serres, and other cities. During the period 1918, 73,974 portions were issued by the Athens kitchens, and 23,631 during the period 1918-1919. Other activities along this line include the school colonies of Vouliagmeni, (in which sickly children are received for their holidays); the school polyclinics in the Piraeus, in Athens and in Smyrna. During the period 1915-1920, 36,906 children were treated at the Athens polyclinic; between 1918-1920, 25,974 were treated at the Piraeus clinic, and 5,305 in the Smyrna clinic during the same period, without distinction of race or religion. School baths were established in Ithaca, Cephalonia, Trikala, Lamia, and elsewhere.

SCHOOL DEPARTMENT OF HYGIENE

The Department of Hygiene consists of a Director of School Hygiene (who has offices at the Ministry of Public Education, and controls the entire department), sanitary inspectors of schools and school doctors. Sanitary inspectors of schools (12 in number) have offices with the Inspector of Schools. They are responsible for the construction and working of schools according to the principles of hygiene, for the protection of children against infectious diseases by advising preventive measures to be adopted, and for the supervision of the physical development and health of the pupils. They control vaccination and revaccination, and submit reports to the Inspector General concerning all questions connected with school hygiene. School doctors exercise the same functions in primary schools. A law was recently passed, establishing special courses to be taken by school doctors and school sanitary inspectors before obtaining the diploma qualifying them for work of this nature.

Hospital Library and Service Bureau

IN a recent letter to the American Child Hygiene Association, Dr. Frank Billings, Chairman of the Library Committee of the Hospital Library and Service Bureau, says:

"We have all long realized the need of some source from which definite information, data and reliable figures on all of the many phases of hospital construction, organization, and operation could be obtained. Interest in hospital work from any standpoint develops at once a call for data and figures, or the average of a definite class or a distinct organization. To supply these will require a carefully organized and comprehensive collection of all obtainable data about hospitals for study and advance compilations—that answers may be available promptly.

"With financial aid from the Rockefeller Foundation, the American Conference on Hospital Service has undertaken to organize and operate the Hospital Library and Service Bureau to meet this situation. We need cooperation, interest, and assistance from your organization, as an organization, and also from your members individually. It will be necessary to ask many of them for information and it is quite desirable that they be informed as to the purpose of the request, and the use to be made of the information. They should know that their connection with the work of hospitals through membership in the American Child Hygiene Association entitles them to apply for and receive, free of any charge, any information and data which the Library has collected. We must call attention, however, to the fact that data must be collected before it can be given out and this will require a little time."

"The proposed library and service bureau will collect, classify for reference use, and distribute types of data as outlined above. Pamphlets and data will also be collected and filed in such form as to be readily available to make up bundles in answer to inquiries.

Clientele to be served:

(1) Hospital, medical, nursing and health organizations and publications; and the trustees, organizers and proprietors of these.

(2) Hospital organizers, trustees, superintendents, medical staff members, department heads and other executives in official capacity or as individuals.

(3) Building committees and committees organized for the promotion of a hospital project.

(4) Directors of dispensaries and first aid workers in industries, schools and colleges.

(5) Architects.

(6) Public officials.

(7) Others having practical needs."

Recent Literature on Mother and Child Welfare

Book Review

The Almosts. A study of the Feeble-Minded, by Dr. Helen MacMurchy, Boston and New York, Houghton Mifflin Company, 1920.

Thomas Fuller, who once was chaplain to King Charles II, wrote a treatise on "The Holy and Profane States," in which a chapter was devoted to "natural fools". "A fool, and a wise man," said this seventeenth century moralist, "are alike both in the starting place—their birth, and at the post—their death; only they differ in the race of their lives." As most of us know, the life race of the feeble-minded has always in the past aroused some sort of interest; thus among certain primitive peoples the "natural" has been venerated; in the seventeenth century when Fuller wrote, he was laughed at; today we seem to ignore him altogether, or at least to forget his needs.

In a work which combines the critical acumen of the literary craftsman with abundant clinical experience in the study of morbid psychology, Dr. Helen MacMurchy endeavors to focus public attention on the educational needs of these children who never grow up. Realizing that the great prose artist and the true poet preserves for generations to come unchangeable records of the things he sees and feels, Doctor MacMurchy has gone to the novel and the drama for types of these unfortunate creatures, and has tested each writer's delineations in the light of modern research. By following this method she has unearthed a surprising amount of clinical knowledge in the works of novelists of such varying technique as Scott and Dickens, when these writers have attempted to delineate simple-minded types—as Davie Gellately in "Waverly," or Maggy in "Little Dorrit." Bulwer-Lytton in drawing the character of Alice, and Kate Douglas Wiggin when she describes Alisa Bennett in the story "Marm Lisa," are found guilty of asserting that congenital mental defect can be cured, which is contrary to experience and therefore to fact. That mental defectives are children, who should be and may be trained to be good children rather than social outcasts, is the theme on which Doctor MacMurchy has built most of her constructive criticism.

Victor Hugo in "The Laughing Man," devoted some pages to a description of the grewsome trade which existed in the seventeenth century—that of deforming children so that they might be used as court-jesters and mountebanks. "The efforts of man to procure himself pleasure are at times worthy of the attention of the philosopher" wrote

the French novelist. The "fools" of the King's Court were frequently grotesque mountebanks rather than mental defectives. So it was that Fuller spoke of "natural" fools to distinguish them from buffoons. Rahere, a jester of the Court of Henry I, is reputed to have founded St. Bartholomew's Hospital in London, and Shakespeare in "Twelfth Night" makes one of his characters remark: "This fellow is wise enough to play the fool," and then adds: "And to do that well craves a kind of wit." But the real "fools" of Shakespeare's plays are analyzed by the author of "The Almosts," and she finds evidence that both the Fool in "Lear" and Touchstone in "All's Well That Ends Well" should be diagnosed as mentally defective.

A plea for the rational care of the feeble-minded, forms the closing chapter. "Simple pleasures and occupations are all the feeble-minded need. The occupations of children make them perfectly happy." Kindness and careful individual study and individual attention are not only the need, but the right of these children—this is the lesson that Doctor MacMurchy enunciates in "The Almosts." There may be a few individuals in the world who are not interested either in good literature or social progress. Only these few will fail to profit by reading Doctor MacMurchy's Essays.

—John Foote.

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The Physician's Part

THE future of the race depends upon the child.

The welfare of the race does not depend upon medical treatment of sick children, but upon preventive measures.

The old adage, "An ounce of prevention is worth a pound of cure," is only now being fully realized in its application to the child.

Preventive medicine is only possible with the intelligent cooperation of the public, and the public can only cooperate when it has an intelligent idea of what is expected of it.

The public must therefore be educated. Mothers and fathers must be taught the fundamentals underlying child welfare.

The physician should be the authority in every community on questions of public health. It is, therefore, absolutely necessary that every physician, no matter what specialty he practices, should have a good grasp on the fundamentals underlying motherhood and childhood.

The most fundamental part of every physician's practice is the care of mothers and children, and there is no part of his practice which will pay such high dividends in the future of the community and the nation, and if he does his work well there is no reason why the annual monetary dividend should be passed unpaid.

Any physician who neglects the best interests of the children entrusted to his care is not doing his best for his country.

WALTER REEVE RAMSEY, M. D.,

In International Clinics, S. 30, III, 275.

MOTHER AND CHILD

A Magazine Concerned With Their Health

VOL. 2 MARCH, 1921 No. 3

The Chinese Child

Richard A. Bolt, M. D.

General Director of the American Child Hygiene Association, Formerly Medical Director of Tsing Hua College, Peking, China

INFANTICIDE is one of the customs for which the Chinese have been most frequently and severely criticized. While it is true that during certain periods of Chinese history infanticide was quite prevalent, it must be said that this has been comparatively rare in recent years. Infanticide was carried on more largely in South China, the province of Fukien being especially noted for it.* In that province there were places set aside where the unfortunates used to be exposed and allowed to die. At the present time when forty millions of people are facing starvation in North China, it is reported that infanticide is again on the increase. Parents are sacrificing their children either by exposure or sale. Infanticide is largely the outcome of severe economic stress, but it also has an element of oriental philosophy in it.

The Chinese have never paid much regard to the bodies of dead infants. In certain parts of Central and South China the little bodies are wrapped in straw and placed outside the city walls on racks, called by some "baby towers," to be collected the following day by a dump-wagon.‡

In China, outside the treaty ports, there is practically no propaganda for birth control. A childless marriage receives social condemnation. Sterility is looked upon as a blight and the gods are implored to fructify the family. The home life of the Chinese seems to demand a full quiver of children. Nature has her way in this as in so many other things Chinese.

CARE BEFORE AND AT BIRTH

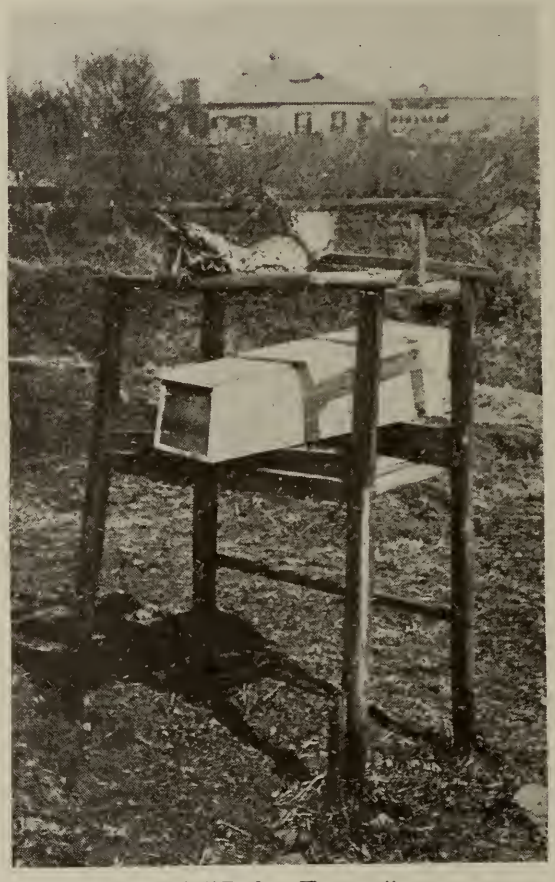
Practically no pre-natal care as we know it is given the expectant mother. Her mind is largely filled with "wise sayings" and superstitions by her mother-in-law and old women of the neighborhood. At the time of confinement, an igno-

* Payne, George Henry: The Child in Human Progress, 1916. p. 66.

‡ Martin, W. A. P.: A Cycle of Cathay, 1896. p. 108.

rant, careless, and usually filthy, midwife presides. Certain women in the community are looked upon as "aids to nature." The fees are very small and volunteer help is often given. Away from the treaty ports and Mission Stations skilled obstetrical care is not obtainable.

Puerperal infection is quite prevalent, but not nearly so common nor as fatal as one would be led to suppose. The greatest difficulty arises in cases where there is some abnormality of either mother or child. In these cases the midwife often interferes up to the point where the life of the mother or child is endangered or sacrificed. Some of the midwives have devised simple cutting and puncturing instruments which they use with damaging effect.



A "Baby Tower"

CEREMONIES FOR THE NEW BORN

The Chinese infant opens its almond eyes upon a stern, plodding, work-a-day world, but a world, nevertheless, full of wonder and romance. From its earliest days it gains, as if by instinct, impressions of hoary ancestors and a dreamy past. The traditions and superstitions of all the centuries have been distilled and preserved as if by magic and are found today in various guises throughout the length and breadth of China. Few countries are richer in folklore and traditions.

From the day of its birth the Chinese child is initiated into oriental mysteries. On the third day the baby is taken by its relatives or nurse to appear before the family shrine containing the ancestral tablets. This shrine is usually in the same house or compound in which the baby is born. Red punk tapers are lighted before the tablet and the nurse with the infant in her arms bows down three times in front of it. On the tablets are characters signifying heaven, parents, teachers, Emperor and earth, reading from above downward. Thus very early the child is taught to come into proper relations with the "five essentials."

BABY BOYS WELCOME HERE

If the child is a boy he is always welcomed with great rejoicing, especially in the case of the first son.

Many felicitations are extended the fortunate parents. A girl is usually received with indifference, often with regrets and sadness, although if the family already have a son or two the daughter is received with more grace. The ideal Chinese family consists of two boys and two girls, but we find the average with five or six children and in many instances families with eight or ten.

Boys are greatly desired because of the necessity of carrying on uninterruptedly the worship of their ancestors. They are also recognized as assets on account of the productive work they will do eventually. Girls, on the other hand, are looked upon as drags on the family, an expense without adequate returns to their parents, before and at the time of marriage. Dowries out of all proportion to the family income are often expected and provided. The girls are subjected to cramped social conventions. Up to the time of the Chinese Revolution the feet of multitudes of Chinese girls were bound, beginning at the tender age of three or four years. Happily this painful custom is rapidly being abandoned.

BIRTHDAY GIFTS

On the third day relatives and friends gather and present colored eggs to the mother. The color is usually red and the number varies from three to a hundred or more. An odd number * is usually given for the birth of a boy and an even number for a girl. This custom of giving eggs at the birth of a child stretches way back into antiquity. It probably typifies the potentialities wrapped up in a new life.

Other gifts are presented to the child such as brass, silver or gold amulets suspended upon red silk cords to be hung around the neck. These are usually stamped or carved with Chinese characters signifying long life, wealth, prosperity and happiness. Daintily embroidered cloth shoes are a favorite gift. These may be worked in multicolored silks to represent, at the toe, a cat's face or some fantastic creature.

NAMING THE CHILD

The Chinese child is usually named also on the third day. This is not a simple matter. Very seldom is the name selected before it is born. During the first three days the parents and friends must canvass the whole category of their ancestors' names, as it is very important that they should avoid giving to the child the name of any of its known ancestors. If the name selected is later found to be that of one of the ancestors, it must be changed. Of course the number of surnames in China is quite limited, it being said that there are only

* In China odd numbers are regarded as lucky, the number five being used much as the ancient Hebrews did the number seven. There are five virtues, five human relationships, five cardinal sins, five elements, five directions, etc., etc. The new flag of the Chinese Republic has five colors, representing five great divisions of China.

one hundred such names of the "first families." Besides the name given on the third day the child usually receives a pet or "milk name." These names are retained until the child goes to school, when it may receive another name. If the boy grows up and becomes an official he is dubbed another name. And if he becomes eventually a great man and receives numerous honors a new character may be attached for each new honor. The limit was apparently reached when the Old Empress Dowager acquired sixty names!

First Lessons With Chopsticks

THE CYCLE OF CATHAY

Although birth registration has never received official recognition in China, every household is supposed to keep strict account of the birth of the children. Births used to be reckoned as a part of the Cycle of Cathay. They were stated as occurring in a certain year of the ruling dynasty, the month of the moon, the day of the month and even the hour of birth being noted. This was deemed essential so that the horoscope of the child could be readily consulted and its fortune determined.

BREAST FEEDING UNIVERSAL

Breast feeding may be said to be universal in China. The children are nursed at the breast over long periods, sometimes as long as three years. There is no definite spacing of the nursing periods; the child is usually fed when convenient, every time it cries, or appears to be hungry. It is really astonishing to see what a large quantity of milk can be developed by the nursing mothers. In some parts of China it is not uncommon to see a child of two or three years running after its mother and nursing at one breast, while a new baby is nursing at the other. If the mother dies, or on account of some extraordinary cause cannot nurse the baby, other members of her own family — sister, cousin or even her mother — may be drafted. If her own household cannot supply the nurse, it is usually easy to find some good hearted neighbor who is willing to assume the function of wet-nurse. Nursing is protracted both for reasons of convenience and economy.

ARTIFICIAL FEEDING

In the large cities and where foreigners have traded, both the nursing bottle and proprietary foods have been introduced, but the Chinese do not take to them readily. Fresh cow's milk is unknown in most parts of China. The Chinese

dislike raw milk, but they are rapidly acquiring a taste for the sweetened condensed milks, and these are being used in some places for infant feeding.

Weaning usually begins in the second or third year by the substitution of thin rice gruel and later on by the addition of vegetable soup. Fats and sugar in some form are soon added. At this period, which is a most dangerous one for the Chinese child, it may be given raw fruits, green vegetables and nuts. A favorite lollypop is a stick of small red fruit, like the crabapple, which has been dipped in a thick syrup and allowed to harden. It is not unusual to see a child of three years munching a hard raw pear or chestnut. About this time the child is introduced to the use of the chopsticks which it learns to handle with remarkable skill.

Of course acute gastro-intestinal upsets do occur, especially at the weaning period when pernicious habits of feeding may be introduced. Mothers have been seen to take tough morsels of food in their mouths and chew them thoroughly before entrusting them to the baby. When famine stalks abroad in the land, as at present, the children of tender years from two to six suffer tremendously. It is pathetic to find that although the mother may be reduced to the verge of starvation, she will still try to keep her baby at the breast. The younger children apparently do quite well up to the mother's final breakdown. They may, however, show distinct signs of anæmia and malnutrition.

RARITY OF RICKETS AND SCURVY

One of the most striking things to a foreign physician interested in Chinese children is the absence of bow legs, beaded ribs and large square heads among them, conditions usually associated with rickets in this country. All observers are of the opinion that rickets is exceedingly rare in China.* I myself did not see a typical case during six years' residence there.

Scurvy is also very rare and is scarcely ever seen outside the treaty ports, where mothers may be persuaded to drop breast feeding and put the child on proprietary preparations. The absence of rickets and scurvy in China has been explained in various ways. Some of the factors to be seriously considered are the universal prevalence and long continued breast feeding; the comparatively open air life of Chinese children; the early introduction of vegetables and fruit juices into the child's dietary; the freedom from native patent foods and the absence of the nursing-bottle.

BERI-BERI

A nutritional disease of great interest affecting the young in certain portions of China, notably the South, is beri-beri. This is seen largely in those parts where large quantities of highly polished white rice are eaten to the exclusion of fresh vegetables, beans or wheat

* Jeffrys, W. H. and Maxwell, J. L. The Diseases of China. 1911. pp. 262-263.

products. This disease has been quite prevalent in Japan and the Philippines. Beri-beri is well known in two types in adults. Its existence among nursing babies was first definitely pointed out by Hirota * in Japan and later conclusively proven by Chamberlain, Andrews and Vedder ‡ in the Philippines. It was noted in many cases of nursing mothers suffering from beri-beri that their babies became ill and a number of them died with acute dilitation of the heart.

In the city of Manila the infant mortality rate was unusually high at one time and the strange fact was that the mortality rate was highest among breast fed babies. This led to a very thorough investigation which proved that mothers suffering from beri-beri, because of the lack of certain vitamines in their food, could transmit the disease to their babies through the milk. Andrews, Chamberlain and Vedder were able to take typical cases of babies feeding at the breast of beri-beric mothers and simply by giving them concentrated doses of the extract of rice polishings to cure them completely, although they continued to nurse their mothers. Beri-beri among Chinese babies in Manila also occurs and it has been noted in children in Central and South China.

LITTLE CHOREA, FEW HEART CASES

Among older children, chorea (St. Vitus' Dance) is exceedingly rare. Testimony to this fact is obtained from practically all who have had anything to do with Chinese children. Hand in hand with this is the fact that Chinese children suffer very little from acute inflammatory rheumatism. Physicians of wide experience in China have said, "We have never seen inflammatory rheumatism in Chinese children." In my six year's experience among Chinese students I can confirm these observations and in addition state that acute tonsilitis and chronically enlarged tonsils were comparatively rare. In an examination of over a thousand young students' hearts very few organic heart lesions were detected. The ordinary causes of heart disease in western countries do not prevail in China.

TUBERCULOSIS

The insanitary conditions of life in crowded villages, the unhygienic habits in the homes, the lack of isolation in open cases of tuberculosis and the close association of children with adults throw the children into early and continuous contact with tuberculosis. Tubercular meningitis and peritonitis are quite common manifestations of the disease in Chinese children. Early phthisis, tubercular glands and bone lesions are found in large numbers. The death rate from tuberculosis in early

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* Hirota, Z. Ueber die durch die Milch der an Kakke leidenden Frauen verursachte Krankheiten der Sauglinge. Central. f. inner Med. 1898. p. 385.

‡ See Vedder, E. B. Beri-Beri. 1913. pp. 242-43 and Bibliography, pp. 330-336.

childhood is high. Jefferys calls tuberculosis "the curse of Chinese childhood."

SYPHILIS

Syphilis is also widespread throughout China. It attacks, as in other civilized countries, all classes of society. It appears in China, however, to be of a milder type and less devastating than in the West. In view of this it is extremely interesting and puzzling to find comparatively little typical locomotor ataxia in China. While very little study of congenital syphilis has been made it is thought to be quite prevalent and the chief cause of the large number of abortions and early deaths. The manifestations of syphilis in early childhood are apparently mild.

A Chinese "Little Mother"

SKIN AND EYE DISEASES

Skin and eye diseases form perhaps the greatest bulk of the diseases of childhood, at least these are seen more frequently in the dispensaries. It is the exception in certain parts of China to find children who show no impetigo, ulcers or boils on the body, whose heads are perfectly clean and whose eyes do not reveal some degree of inflammation. Trachoma is omnipresent and one of the important causes of defective vision and blindness.

INTESTINAL PARASITES

The Chinese child is an aquarium for intestinal parasites. The round worm, tape worm, pin worm and others are found in varying numbers in 90 to 100 per cent of the children. In the South and along the Yangsze hookworm adds its quota. The parasites are looked upon with complacency and to all outward appearances bother the children but little. Dysentery is quite common and is found in both the amoebic and bacillary types. It is often very severe and forms an important cause of children's deaths. The prevalence of intestinal parasites is easily accounted for by the unhygienic habits of the children, the methods of sewage disposal and fertilization of the soil with human manure. In fairness to the Chinese, however, it should be

mentioned that they do not care for cold foods, practically all foods being thoroughly cooked and all water boiled and drunk largely in the form of weak tea. The hot, steaming towel for face and hands is freely used among the better classes both before eating and between the courses of the meal.

MORTALITY STATISTICS

It is very difficult to draw any conclusions as to the infant mortality rate in China. In the first place the exact population of the country is unknown. No official birth registration is carried out and hence a birth rate is simply a guess. The mortality under one year of age can scarcely be estimated. It is well known, however, from observation that the annual crop of babies is large and that neo-natal mortality is high.

In a recent illuminating statistical study Lennox * gives a table showing the comparative mortality of children of foreign missionaries in China and of lower class Chinese, based upon 3,254 births in mission families and 8,468 births among Chinese. The number of deaths under one year per 1,000 live births was 60 for the missionaries and 156 for the Chinese. It is pointed out that the number of Chinese infant deaths is unreliable because of the peculiar method of counting ages from the Chinese New Year. From 0-5 years the missionaries had 121 deaths per 1,000 births and the Chinese 272.

SAVING CHINESE BABIES

Any child welfare program for China—if this is thinkable—must seriously take into account the ingrained customs and habits of the people. It must be remembered that there is a passion for offspring, breast feeding is universal, wetnursing is the accustomed substitute, and a racial immunity against the devastating effects of certain diseases has been acquired. What is needed as first steps are pre-natal care and better midwifery, general sanitation and hygiene, the prevention of tuberculosis and intestinal diseases. These can largely be effected through education and better economic conditions. The first is making headway, the second will come when other nations cultivate rather than exploit China.

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* Lennox, Wm. G. The Health of Missionary Families in China. Department of Economics, University of Denver. 1920. p. 24.

[*Note: The illustrations used in this article were made from photographs furnished by Dr. and Mrs. Walter Libby, of Wuhu, China.*]

Day Nurseries as a Factor in Infant Welfare

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ARE Day Nurseries necessary in the prevention of sickness among children, what is their peculiar opportunity, what are they doing to enhance this opportunity, and what improvements can they make? These are the questions I want to discuss.

You will pardon me if I take a few minutes to tell you first how I came to be interested in Day Nurseries. Over a year ago Doctor Charles Mixter asked me to find him a children's specialist to work at the Trinity Day Nursery in East Boston, and it occurred to me at that moment that I might as well do it myself, as I knew nothing about them. I found that the doctors at the hospital, who are interested in everything pertaining to children, knew no more than I did about nurseries. Here then was a new field.

I made a thorough physical examination of all of the children, and recorded these examinations. I found many heads infected with nits. I found many cases showing carious teeth, and these were taken to the Forsythe Dental Infirmary for treatment. Where enlarged or diseased tonsils were found, an operation was recommended, and arrangements were made for their removal at the Children's Hospital This was done with one girl who had heart disease. She was also taken out of school and made to rest at the nursery. Another child with chronic intestinal indigestion was put on a suitable diet, and his mother was invited in to talk the matter over, so that she could be told what the trouble was with her boy, what the treatment consisted of, and the necessity of her cooperation. Two children were sent to the Psychopathic Hospital for mental tests, and one of these, with undesirable moral habits, was recommended for exclusion. We measured and weighed the children, and picked out for special attention those who were below ten per cent in weight for height. I went over the diets with the head worker and checked up the kinds of food, and the number of calories the children were getting. Then I inspected the whole building as to sanitation and as to protection against fire. Finally I visited five other nurseries, and, after seeing what they were doing in the way of protection and of education, I had a good idea of

what a day nursery is, and how much it contributes to the health, happiness and efficiency of a community. It was interesting to see how easily they become community centers, with meetings for the mothers and the fathers, and with classes for the older girls and boys. I wish there were more of them, and in my own work I find help here where I was at a loss before. In all of these nurseries I found but few babies.

THE WRECK OF HOPES

On seeing the many children of foreign parentage and the children of couples who have come to grief through one cause or another, one is struck with the melancholy spectacle: this wreck of hopes. In case of aliens,—here lies the end-result of adventures undertaken with high courage. They set out for the Land of Liberty and Opportunity, only to have their plans dashed by misfortune, sickness, and death. Here also is the result of poor marriages or lack of marriages. The one hope of a good final outcome remains with the children. They must be cared for. Help must be given to a surviving parent who clings desperately to the remains of his family. If responsible people do not care for the children, irresponsible people will. The recent discovery of a nursery on Tremont Street, in Boston, where babies were taken only to be neglected, is an instance of what every worker knows is going on, and would go on to a much greater extent if responsible day nurseries were not keeping these agencies at their present high level. Day nurseries are eminently necessary.

REACHING THE PRE-SCHOOL CHILD

"The attitude of a nation toward child welfare," Herbert Hoover has said, "will soon become the test of its civilization." If you consider the thirty-six per cent of young men rejected for service in the army by the draft boards you can agree heartily with him. For the safety of the country depends upon the physical fitness of our young men. Twenty-one per cent of these men were rejected for defects of eyesight, eight per cent for defective teeth, and six per cent for defective ears. To guard against these defects which must be corrected early, every day nursery can help. Again, we must have perfect functioning of the human machine, not only for war but for success in any walk of life. I live near an eminent man who can work, and work hard. Many nights when I am going to bed, tired out, I see his light burning in the study, and before I am dressed in the morning I see him starting vigorously off to work. I know a man who has worked with him and he says he has tried, but he has never caught him loafing. Now you cannot work at this high tension unless you have perfect health. And the foundation of health is laid in early childhood. We must prevent illness and consequent disability when the correction is easy. The rate of diffusion of knowledge is discouragingly slow, and we must use every means

at our disposal of fighting the difficulty, of teaching poverty-stricken, forlorn, ignorant, and prejudiced people. As yet proper value has not been given to day nurseries as a helping agent.

DOING VERSUS TEACHING

Now as to your opportunity. I should say that all the world loves a child. Here we have a great common tie between Infant Welfare Workers and parents in distress, a tie which makes for an understanding of one another. I know by experience in clinics what kindness can do. It holds for day nurseries. And the actual doing of a thing is worth more than merely pointing out. In a day nursery we do more than simply advise; we do. It is important to take into consideration the point of view of parents who speak a foreign language, who were brought up differently, and who have convictions as to the methods of bringing up their own children, the proper kind of medical treatment, and the need of sanitation. Here is our opportunity. They offer us their children to do with almost as we will at the most plastic time of their lives. What we teach the children becomes a part of them, beyond the power of the parents to nullify. Let parents talk to these children in Italian; the answer is sure to come many times in English. Let the parents doubt or scoff at the value of fresh air and cleanliness; their prejudices

The Worcester Day Nursery—A Place to Play in Bad Weather.

count for almost nothing. These children are beginning to have prejudices of their own and of the right kind. It means, this education of plastic individuals, that they step in advance of their parents; their children-to-come will start life with a better chance.

It is a wonderful thing to be a great man. It is almost as wonderful to be the father or mother of one. They share in that glory who for these children take the place of a protector. I have hopes that some day a baby, whose life has been saved on The Floating Hospital, will become a great man; it may yet be the lot of a day nursery to rear an Abraham Lincoln.

THE MOTHER'S ANXIETY

But for the most part we are to deal with boys and girls who will become ordinary but valuable men and women. Our duty is to protect and educate them. These are the functions of a day nursery. A child is kept safely while his mother is away at work, and her mind is at ease because she knows he is out of harm's way, safe from accidents and evil companions, and under conditions where he is taught to guard his health. It is by keeping children well that we diminish their chance of becoming sick through a lowered resistance. The health of the community is by so much conserved because it is saved from just that many foci of disease.

Now let us look at the methods we use for keeping these children well. We prevent their neglect. Left to the parent who hesitates to lose a day's work which is necessary to take his child to the hospital clinic, the child may not be treated at all, or too late. Once in the nursery the child's needs are seen to. Bad throats, for instance, are a real menace. We know that removing diseased tonsils actually lessens the possibility of a second or more attacks of rheumatic fever. This disease is directly related to heart disease, and heart disease is the foremost cause of death among adults. Many children with heart trouble do not live to become adults, because attacks of rheumatic fever kill them early. An ounce of prevention is worth a pound of cure. What they need is a pound of prevention.

We protect them from disease by keeping them clean. Tooth brushes, combs, wash cloths, and clothes are kept separately, so that there may be the minimum chance of contagion. We protect them by giving them good food, and by keeping them warm and dry, and by giving them rest in the day time. They are given fresh air, and in some nurseries they are sent into the country in the summer time. Truly these children are protected as well as the children of rich people.

And we educate them. By no means the factor of least importance in our nurseries is the maintenance of discipline; the instilling of the love for law and order. Parents complain to doctors that they are told what to do to care for their children, but not how to do it.

UNDISCIPLINED HOMES

The main trouble with many parents is within themselves. How can you teach a lax mother to bring up a boy with real character? No one knows. Now where mothers have to work, discipline must lag. Hence the great value to these children of being compelled to obey. Fifty per cent of the upbringing of children lies in their management. We have babies brought to us on The Floating Hospital who suffer from nothing less than a lack of law and order. After a stay on the Boat on the same milk formula on which the baby was sick at home, the child is sent back well, because we gave the food in proper amounts and at proper intervals, and let him alone so he could rest. In the Children's Hospital, case after case comes to us because the child is peevish, anæmic, thin, and without appetite. Too much candy and too little rest is their trouble. We tell the mother this must be remedied, and she says it is impossible. The child refuses plain food, refuses to go to bed early, and cries until he has his own way. Our hope in these children in the clinic is that they are old enough to see for themselves, when placed in a nutritional clinic, that children of their own age are stronger than they are because they drink more milk and take more rest. Thus for discipline we substitute self-interest. Now in a day nursery we can and do have discipline. We do not have to advise the mother. For one half of the twenty-four hours we make her child mind,—and half a day is better than none.

First Lessons in Loyalty.

MAKING NURSERIES SAFE

So much for what a nursery does for its charges. What more can it do? First, every day nursery should have a trained nurse, who will be the source, ready at hand, of practical medical knowledge. She can be trusted with the task of excluding, the first thing in the morning, the children who report with symptoms of early contagion. Under her eye a child who is not gaining properly can be watched carefully. In her the sense of medical cleanliness is highly developed. She is the enemy of dirt, of flies, of pediculi, and of beginning skin disease. She knows where to look for trouble. She is indispensable in carrying out the doctor's orders.

Secondly, each day nursery should have a doctor in attendance

who is interested primarily in children's diseases, and interested in one particular nursery. This can be done easily in a medical center like Boston. There it is possible to make use of the graduates who come to the Harvard Medical School to study for the purpose of becoming children's specialists. These men, often of great experience in general practice, would be of greatest value to a nursery. There are many advantages in having a specialist. Much attention could be given to guarding children from contagious diseases; just what children should be sent home and how long they should be kept there. I stress this point so much because people in general know so little about it. Every year there are 9000 deaths from whooping cough in children under five years of age, and the same number from measles. I do not need to dwell on the complications of these diseases. Under the guidance of the doctor and the nurse, children can be taught, and the teaching enforced, how to shun other children with colds, which so frequently are the first symptoms of beginning measles, whooping cough, and scarlet fever. Defects like flat feet, running ears, carious teeth, diseased tonsils, and curvature of the spine can be detected early, and the correction of these defects carried out. The diets of children who are underweight can be surpervised. Now the children themselves learn what a real physical examination is and know the difference between good and bad treatment. When they become of age they will demand good treatment for themselves and for their own children. We may hope that future mothers among the girls will not be satisfied with a midwife.

You educate the community at large by helping to educate these specialists. They are going out all over the country to begin Welfare Work in new places. We should see to it that they go home with a purpose of establishing new day nurseries.

A DEMONSTRATION CENTER

And through these children we ought to influence the neighborhood. I would have each day nursery a demonstration center of how children should be cared for; the proper cooking of food, the right kind of food; the kind and amount of clothes; the economic buying of food and clothes; the proper temperature and ventilation of a room; the value of sunshine; the means of managing wilful children, and the proper medical supervision. There ought to be a more powerful method of reaching the neighborhood than word of mouth. This is too slow. Mothers are interested in matters pertaining to their children; but ignorant, foreign-born mothers read nothing. They might read a simple, perhaps illustrated, leaflet, in their own language, which they knew would tell them things they need to know about children, but this is untried and expensive. It comes back to what you can teach them by word and deed at the nursery.

Thirdly, we take care of children, but we should bend our energies more to taking care of babies. It is very difficult at the present time, almost impossible, to find boarding places for babies. This means work. It is not profitable. No one wants them and they are not sick enough to go to a hospital. We are placed in the position almost of allowing a baby to continue under his conditions of neglect until he is ready for the hospital. Few people who are willing to take care of babies can do it properly. It should be done with the assistance of a nurse, under the supervision of a doctor; and it should be done by people who realize the value of saving infant life.

Finally, we need team work among the nurseries. We need an association, particularly in Boston, which can take up as a whole important improvements and needed reforms. We need the help of other agencies doing Infant Welfare Work and they need ours. Concerted action is the means of getting results most efficiently.

Here, then, we have in a day nursery, a home for children in their own neighborhood, with special facilities for guarding their health and for educating them, for their own good, for the happiness of their families, and for the well-being of the community. We have the opportunity of actually doing beneficial things, not merely advising them. We detect defects and we see that they are corrected. We apply directly the factors of fresh air, sunshine, cleanliness, good food, rest, and play. We are doing real Infant Welfare Work.

A Playroom in the Worcester Day Nursery.

Day Nurseries and the Pre-school Age Child

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THREE important points in connection with the child of pre-school age have only recently become matters of common knowledge:

First, and most important, that he is being systematically neglected, and has had no attention paid to him comparable to that offered by Infant Mortality Organizations to the younger child, and by the care given in schools, and otherwise to the child of school age. Second, that the child of pre-school age is subject to a rather higher percentage of disease incidence than that of the older group, and when so attacked, presents a higher mortality rate. Lastly, that better results are obtained in treatment, and what is more important, greater opportunities for prevention are offered at this time of life than ever again obtain.

During the war a large portion of the children treated in the Red Cross Health Centres were of pre-school age, and were greatly in need of the kind of preventive education given them there. General statistics, such as those recently presented by Doctor Rose on the condition of health of the school age child, indicate plainly the great need of such preventive work as is carried out more intensively each year, by many organizations interested in child health. Their effort has been primarily educational; and, secondly, having picked out the sub-normal child, to provide him with such care and instruction as is necessary to put him into the normal list.

PREVENTION AND EDUCATION

Such work is a necessary supplement to that which has already been done for many years in the various children's clinics and dispensaries of the city. Here, although naturally more concerned with the treatment of disease than with prophylaxsis and education against it, they are stressing the latter more than before, and indeed, show their chief advance in efforts along this line of prevention and education.

It is true that child health activity in New York has had to do more with the school age than with the pre-school child. Yet the slogan of one of our best organizations: "Education in Health, Health in Education," well expresses their real intent of prevention, by combating ignorance in health matters. Their effort *must* lead them eventually more and more into this younger group. Effective education in the pre-school child will make un-

necessary much of the treatment which is found to be needed today by the school child, and is, therefore, of double importance. It seems really, if there is a keystone in the arch of child health, that it finds its place in this pre-school age.

STRIKING FIGURES

We had in New York City in 1919 a few less than 400,000 children between the ages of two and six, and during that time there were only 3,850 under observation and care. This is a striking fact, when we consider that the mortality rate among them stands between that of the infant and the school age, being lower than in infancy, and higher than the school age.

In 1918 there died in this country 168 children per thousand under two years; 39 children per thousand from two to five years of age, and 26 per thousand from five to nine years. Added to this is the fact that the predominant *disease incidence* in this age is of such a sort as is most likely to lay the foundation of those defects frequently found and treated in the school child. Given so large a group to work on, of which so far barely one per cent has been reached,—a group known to be victims of conditions frequently easily preventable, which are predisposing them to future disease, it is evident that the Day Nursery is preparing to meet a most important need.

OPPORTUNITY FOR DAY NURSERY

Surely, for this age, there is no spot better adapted to such work than the Day Nursery. The pre-school age child is not new material, the foundation has already been laid for his health education indirectly by contact with his mother during his infancy. Few, if any, of the fundamental principles of hygiene are beyond the grasp of these children, provided they be presented interestingly and in a manner adapted to the age of the child to be reached.

THE SUBJECT MATERIAL

What promise of results can this group offer us? Are the chances of success as good as in infant welfare work, or among children of school age? How far is a child from two to six years of age receptive to, and capable of, health education, and to what extent can he retain and apply the principles which are taught him?

In the first place this pre-school age child is not a link in a chain; there is no line of distinction between the stages of childhood. The course of a child's development from infancy to maturity is too gradual, and each phase is too closely interdependent, to allow of any definite demarcation between the infant requirements, needs and limitations, and those of the pre-school age, or later of the school age.

For this reason, there is no period which can safely be left out, if we are to direct this development along such lines as will result in normal adult life. He is developmentally quite ready to furnish fertile ground for impres-

sion and prompt response to direction and education. What he lacks in constructive reasoning, he makes up by a very acute instinct, a normally urgent desire for approbation, and a natural tendency to mimicry and emulation. He has not yet formed fixed habits, which must be undone, his time is not yet absorbed by school duties, and for this reason your contact is better than it may be later. A natural preference for nourishing types of food, regular habits in eating, and in the care of the body in general, understanding of the necessity of regular and free elimination, recognition of the sense of comfort that comes from proper ventilation, in short all the basic principles of hygiene, may be quite readily grasped and understood by the child of pre-school age.

In 1918 there died in New York City from—

	Children under 5	Children from 5 to 9
Acute Infectious Diseases..	2,474	842
Tuberculosis.....	722	165
Cardiac Diseases.....	139	142
Respiratory Diseases.....	6,347	607
Burns.....	235	83
Nervous Diseases.....	453	120
General.....	5,059	1,084

In connection with these figures it is well to bear in mind the fact that of the 400,000 children of this age in New York City, only 3,850 were under observation.

So much for the material which the pre-school child offers, as a subject for your effort. A few figures will show where the pre-school age child stands in relation to the school age child in the matter of disease incidence.

THE METHOD

What should be, then, your necessary equipment in carrying out this attack? As education is really the primary object that we have in mind,—education, not alone of the child, but through him, of his parent,—you must be prepared to stimulate his interest in this game of health.

No better plan for this has been offered than that of the Child Health Organization with its fund of material for presenting the health subject; allegorically, as in their plays and stories, by pictures, and by rhymes and books, by the personification of the factors in health, in such a way as to make more concrete these otherwise abstract elements. Thus in general the subject may be introduced to the child, then in particular, he must be taught to apply these general principles to his individual self.

Here comes in the real reason for the preliminary and periodic subsequent examinations to which every child, in every institution, whether it be a Day Nursery, or nutritional center, a school, or an asylum, should be regularly subjected. Such examinations, and the statistics which result upon them, should not be considered as being done for your general information upon the condition of the children with whom you are dealing, as much as for the particular information of each child, to show him where he stands in the scale of

physical perfection. Here is it important that the child should not be loaded up with the burden of consciousness of his, or her, physical lack of fitness. On the contrary, he should be made to interest himself in the matter of his progress, he should be shown that progress in growth, in weight, success in the betterment of the condition of his teeth, of his regular bodily habits, adherence to the rules of fresh air, diet, cleanliness and exercise, are the points to be earned in the competitive game of health. Healthy rivalry in such competition should be stimulated, both in the individual child, and in the group to which he belongs, and examinations conducted often enough to make this competition a live factor in his Day Nursery life. Therefore, preliminary and periodical examinations of the child, including his weight and height, inspection of his teeth, throat, eyes, the testing of vision and hearing, a complete investigation of his habits, and bodily functions, a determination of the correctness of his posture, his muscle tone, the condition of his blood, is necessary, not for a matter of record, but to show him from time to time where he stands in relation with his fellows in the matter of physical fitness.

THE PROPER AGE

It is perfectly apparent that the pre-school age is the time for this effort; any time before the child enters upon his pre-school age is too early to enlist his cooperation. Very frequently the school is *too late* to correct conditions which have grown up from neglect during the pre-school period. Lack of good habits at this age, equally with the result of bad habits, are responsible for the one greatest draw back to our present school life, that malnutrition, which exists in from twenty to thirty per cent of our school children. Our nutritional clinics are peopled by children over six years of age; they draw their members from the school age child. The *opportunity* then in the pre-school age is to *prevent* the conditions which the school age presents, all too often, for treatment and cure.

How true this is, is shown by an analysis of the health conditions of our 22,000,000 school children in this country. The statistics of Dr. Woods show some defect in a minimum of 19,000,000 out of this 22,000,000. Of these 19,000,000 children who are defective physically, at least 15,000,000 are defective for reasons which are easily preventable. Such so-called *minor defects* as bad teeth, enlarged adenoids and diseased tonsils; equally with the results of poor hygiene,—bad dietaries, are directly responsible for such *major disease* as tuberculosis, heart disease, and above all malnutrition in the older child. These things are *treated* in the school child, but could be, and will be *prevented* during the pre-school age.

PREVENTABLE DISEASES

As a future illustration of the possibilities of the prevention of

disease at this time, take the cardiac group alone. Heart disease usually does not appear until between the fifth and tenth year. However, its foundation is laid during these pre-school years. Perhaps ninety per cent of these cardiac children have acquired this condition through the constant absorption of toxins from bad teeth, or from diseased tonsils. The elimination of these two sources of trouble is very simple, and certain, and of infinitely more value as a preventive measure than when done later to remove the possibility of *further* trouble in the school child. Such operations are being done in New York City today to the number of thirty to forty thousand a year, and thirty per cent of these applying, are applying *not* for the removal of a possible source of injury, but on the contrary, for the removal of proven source of injury which has already caused serious damage. In other words, *too late* to produce results that otherwise might easily have been obtained. We may say, therefore, that proper care of the pre-school child would at once eliminate one-third of the present candidates for late operations of this type.

Curative measures, if they could be applied successfully to our children of school age, would perhaps overcome, even if late, much of the physical unfitness which exists today; but in the struggle for existence, and the resultant constant fatigue which applies to every mother, it is difficult to institute adequate *home* treatment, and *institutional* care is not available for a great number; therefore, the damage which has been done is, in many instances, permanent.

AN ECONOMIC DRAIN

Economically the results are all too apparent; the addition of the care of a sick child to the other household duties of a mother, reflects itself in terms of neglect of the well children in the family, and so reduces by just that much, their chances of growing up well and strong. The subsequent burden to the State of these partial or complete cripples is almost as heavy as our pension list.

It seems fair to repeat then, as we have said before, that the pre-school age is the time,—the time, not only to inculcate in the children such habits of life as will better their chances of growing up into constructive, rather than burdensome citizens, but also the time to *prevent* the development of such conditions as later on are going to limit the efficiency of those physically able; the time to reduce the burden of the care of a dependent class.

The child of the school age offers a small period of time each week in which to give health instruction and training; the pre-school child is reached at a period when his life is less crowded.

AN EDUCATIONAL CENTER

The Day Nursery is the ideal place for such an effort to be made, because the children are there over a longer period of time, and be-

cause such instruction as may be given carries with it the morale which the position of the Day Nursery in the community has established; its role as a helper, adviser and friend, has already opened the way for a prompt and complete acceptance of advice as to health, which perhaps does not apply in such degree to any other source from which advice might come. The function of a Day Nursery can not be passively to provide a dumping ground. It must be an active educational centre. Parental compensation without education would fail its purpose. It is more than a simple problem in bettering the condition of these nursery children; it is a problem that reaches out widely, and will ultimately affect the economic state of the country, and will better, not alone the child who has come under your care, but every other child born or unborn, who has to share his life with these potential invalids.

Safeguarding the Health of Working Adolescents

Emma M. Appel, M.D.

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IN eighteen states, a physical examination is required by law before a child can be granted a regular employment certificate—the medical examiner in most cases to be appointed by the local Board of Education or the Department of Public Health. In two of these states, however, Alabama and Massachusetts, examinations by a private physician are accepted. In nine other states the physician is usually appointed by the Department of Health, though in some cases the law does not designate what physician shall be selected, and the issuing officer may use his discretion.

The provisions in the laws of the different states governing the physical examinations vary—the usual clause reading that the child must be of normal physical development and in sufficiently sound health and physically able to perform the intended work. Some states require "sound health", without regard to the occupation which the child is to enter.

The procedure in making the physical examination is determined to a great extent by the practice of

the individual issuing office. In several states, notably, Illinois, Maryland, New York, Pennsylvania, and Wisconsin, an attempt has been made to establish a uniform standard. In each of these states a special form has been devised for recording physical findings, and instructions prepared for the medical examiners.

Where the physician's examination is required, the physician must sign a statement certifying to the child's physical condition before an employment certificate is issued.

At the Conferences on Child Welfare Standards held by the Children's Bureau of the United States Department of Labor in Washington and other cities throughout the country in May and June, 1919, minimum physical standards for working children, or those about to go to work, were adopted:

"A child shall not be allowed to go to work until he has had a physical examination by a public school physician or other medical officer especially appointed for that purpose by the agency charged with the enforcement of the law and has been found to be of normal development for a child of his age and physically fit for the work at which he is to be employed."

"There shall be an annual physical examination of all working children who are under 18 years of age."

A PERMANENT COMMITTEE

At the Washington Conference, in the section on Child Labor and Education, a resolution was passed requesting the Children's Bureau to appoint a permanent committee to formulate definite standards of normal development and physical fitness for the use of medical examiners in making physical examinations for children applying for employment certificates.

The membership of this committee, which consists of physicians who are considered among the best authorities on physical standards for children in industry, is as follows: Dr. George P. Barth, Director of School Hygiene, City Health Department, Milwaukee, Wisconson, Chairman; Dr. Emma M. Appel, Employment Certificate Department, Chicago Board of Education; Dr. Josephine Baker, Chief, Bureau of Child Hygiene, Department of Health, New York City; Dr. Taliaferro Clark, representing the United States Public Health Service; Dr. C. Ward Crampton, Dean, Normal School of Physical Education, Battle Creek, Michigan; Dr. D. L. Edsall, Dean, Harvard Medical School; Dr. George W. Goler, Health Officer, Rochester, New York; Dr. Harry Linenthal, Director of Industrial Clinic, Massachusetts General Hospital, Boston, Massachusetts; Dr. H. H. Mitchell, representing the National Child Labor Committee; Dr. Anna E. Rude, Director of Hygiene Division, United States Children's Bureau; Dr. Thomas D. Wood, Chairman on Health Problems and Education, Columbia University, New York City. Miss E. N. Matthews, Director of the Industrial Division, United States Children's Bureau, has acted as secretary to the Committee.

The Committee held its first meeting in January, 1920, in Washington, and prepared a tentative report. In January of this year the second meeting was held for the purpose of revising the standards and record form in the light of criticisms and suggestions made by examining physicians and others to whom the tentative report had been submitted.

WORK OF THE COMMITTEE

The revised minimum standards adopted by the Committee at its second meeting, January, 1921, are as follows:

Age Minimum.

The minimum age for the entrance of children into industry should be not younger than sixteen years. Since it is recognized that the physiological and psychological readjustments incident to pubescence (which in the vast majority of cases are not completed until the sixteenth year) determine a period of general instability which makes great and special demands upon the vitality of the child, it is of paramount importance that he should be protected during this period from the physical and nervous strain which the entrance into industry invariably entails. The committee recognizes the fact that pubescence may occur early or may be very greatly delayed, and is convinced that the more it is delayed, the more there is indicated a physical stage during which it is highly inappropriate to subject the child to the strains of industry.

Physical Minimum for Entrance into Industry.

No child between the ages of sixteen and eighteen should be permitted to go to work who is not of normal development for his age, of sound health and physically fit for the work at which he is to be employed.

Physical Examination for Children Entering Industry.

The physical fitness of children entering industry should be determined by means of a thorough physical examination conducted by a medical officer duly appointed for this purpose. Where possible all examinations should be made without clothing. Before such a physical examination is made, the child should present a definite promise of employment in writing from his intended employer, stating the specific occupation in which he is to be employed.

Reexaminations for Children Changing Occupations.

The employment certificate should not be given to the child, but sent by mail to the employer. When a child leaves the specific employment for which the certificate was issued, the employer should return the permit to the issuing officer by mail. With each change of employer another examination should be made before the child is again permitted to work, the mode of procedure to be the same as in the issuance of the original permit. When a child is transferred to any occupation in the same establishment differing in its physical demands and hazards from those common to the occupation for which the permit has been issued, this must be communicated by the employer to the issuing officer in writing and a new physical examination of the child made and a new certificate issued.

Periodical Reexaminations for all Working Children.

All employed children up to the age of eighteen should have at least one yearly physical examination to be made by a public medical officer duly appointed for this purpose. Whenever in the judgment of the medical examiner, more frequent examinations are desirable, the child may be ordered to report at stated intervals for this purposes. These examinations should take place either in

the certificate issuing office, continuation school, or in the establishment in which the child is employed.

Centralized Control of Methods of Examination.

In order to insure uniformity in methods of examination in each State, the State Labor or other department administering the Child Labor Law should have authority to make rules and regulations relative to methods of examination and qualifications of examing physicians, to prescribe record forms, and to require reports with reference to examinations made. Each such department should employ one or more physicians qualified in industrial hygiene who shall be authorized and required to supervise the work of the local examining physicians.

Need of Study by Local Administrative and Medical Officers of Occupations in which Children are Employed and of Their Effect Upon Health.

Occupations in which children are likely to be employed should be made the subject of special study for the purpose of ascertaining their physical requirements, and their effect upon the health and development of the growing child. The examining physician should be authorized and required to visit periodically industrial establishments and to familiarize himself with conditions of employment and with the various health hazards of industry.

MINIMUM STANDARDS FOR CHILDREN

While recognizing the necessity of considerable further study, the committee is of the opinion that the results of scientific research already available, and the experience acquired in the administration of laws prescribing physical requirements for admission to industry permit the recommendation at the present time of certain tentative minimum standards, the acceptance of which will aid materially in safeguarding the physical welfare of the child obliged to enter industry before reaching his full development.

1 Standards of Normal Development.

(a) A certificate should be refused to children who do not come up to the following minimum standards of height and weight for specified age, which are based on the most reliable experience and present-day practice.

Age	Weight In Clothing*	Height
14	80 lbs.	58 in.
15	85 lbs.	58 in.
16	90 lbs.	59 in.

* When children are weighed without clothing, not more than five pounds should be allowed for clothing.

[NOTE:—While the committee recognizes that girls of 16 are lighter in weight than boys of like age, it presents but one standard. This is for the purpose of giving greater protection to girls who are to be regarded as more vulnerable at this period.]

In exceptional cases, a child who falls below the prescribed minimum of height or weight may, however, be granted a certificate, if after examination by two physicians, it is found that this condition is a family or racial characteristic, and that he is free from any other defects which would justify the refusal of the certificate.

(b) Certificates should be refused to children who do not show unmistakable signs of maturity.

2. Standards of Sound Health and Physical Fitness for Employment.

(a) Certificates should be refused to all children who have the following defects:

(1) Cardiac disease, with broken compensation.

(2) Pulmonary tuberculosis or

other evidence of serious pulmonary disease.

(3) Active glandular tuberculosis.

(4) Active tuberculous or syphilitic disease of joints or bones.

(5) Total blindness. (Unless no further educational facilities can be provided for such children.)

(6) Total deafness. (Unless no further educational facilities can be provided for such children.)

(7) Trachoma.

(8) Chorea.

(9) Syphilides.

(10) Hyperthyroidism.

(11) Acute or subacute nephritis.

(12) Hook worm.

All children who are refused employment certificates because of physical defects as noted under Class (a) should be referred to some appropriate person or agency for whatever medical or other assistance they need.

(b) Certificates should be refused to all children pending correction of all serious remediable defects, such as:

(1) Defective vision subject to correction by glasses.

(2) Contagious eye and skin disease.

(3) Defective teeth: extraction or prophylactic care needed.

(4) Malnutrition requiring supervision (Grade III and IV) and not under treatment.

(5) Untreated inguinal or femoral hernia.

(6) Diseased tonsils.

(7) Defective nasal breathing requiring correction and not under treatment.

(8) Discharging ears not under treatment.

(9) Orthopedic defects not under treatment.

(10) Intestinal parasites (other than hook worm) not under treatment.

All children who are temporarily refused employment certificates because of the existence of physical defects as outlined under Class (b), should be referred to the care of a public medical officer, school physician, family physician, or school nurse, who should make every effort to see that the necessary medical treatment or other care is secured for the child. As soon as such treatment has been completed, or the defect has been corrected, the issuance of the employment certificate shall be recommended.

(c) Provisional certificates for a period of not more than three months may be issued on recommendation of the medical examiner under the following conditions:

1. Where treatment has been started but not completed, in such cases as:

(a) defective teeth

(b) malnutrition

(c) orthopedic defects

(d) defective nasal breathing

(e) discharging ears

(f) intestinal parasites other than hook worm

2. Partial blindness.

3. Partial deafness.

4. Other defects (not specified under a and b) which in the opinion of the medical examiner require supervision.

Children receiving provisional certificates shall be reexamined before the expiration of the provisional certificate, or at such intervals as the examining physician may deem necessary. If in the opinion of the examining physician every conscientious effort has not been made to correct the defect during the provisional period, no new certificate shall be issued until correction has been obtained.

FURTHER INSTRUCTIONS

Detailed instructions were outlined covering each point in the

medical examination of the child, special emphasis being placed upon significant family history, history of previous illness of the applicant as well as operations, accidents, vaccinations, etc.—history of institutional care either remediable or custodial, name of institution and period of treatment.

Definite instructions were also given to the method of procedure in testing vision, hearing, nose, throat, lung, and heart, and the use of special record blank drafted by the Committee was recommended.

It is hoped that the work of the Committee, in coordinating the many suggestions and criticisms of social and medical authorities on this important subject, may prove to be of value in safeguarding the health of the children who are obliged to enter the industrial field.

WORK IN CHICAGO

It may be of interest to outline the work in the Chicago office. In diagnosing malnutrition, weight in relation to height should be taken into consideration as one of the factors. Relative importance should be given to the other symptoms and findings which make up the symptoms of malnutrition. Children who are 7 per cent below the average weight for their height are examined by two physicians who determine whether or not this underweight is the result of individual or racial characteristics or whether it is due to malnutrition. Refusal of a certificate is justified only when malnutrition is shown to exist.

The above standards are checked with the advent of maturity. Notation is made of the state of development such as prepubescence, pubescence and adolescence. Children who are retarded in physical development from one to three years and who have not entered their prepubescence, are also examined by two physicians who have actual knowledge as to the nature of the occupation at which the children are to be employed.

An especially important piece of work is that done for malnourished children who comprise more than 30 per cent of our school children and working children.

MALNUTRITION PROBLEMS

"Malnutrition," says the Chief Medical Officer of England, "is one of the gravest evils of its (the child's) physique. The malnourished child tends to become disabled and unemployable, incapable of resisting disease or withstanding its onset and process."

The physicians have found that when a malnourished child is allowed to go to work he usually returns from his first position in a worse condition than when he started to work.

In November, 1910, the Board of Education, authorized an examining physician of the Vocational Guidance and Employment Certificate Bureau to conduct nutrition classes in five schools. This work was undertaken primarily to put

into good physical condition children already applicants or soon to become applicants for employment certificates.

The children in the pre-industrial nutrition classes were selected through weighing and measuring tests carried on in the 5th, 6th, 7th and 8th grades among children who soon might become applicants for Employment Certificates. Of 1,370 children weighed and measured, 174 were selected for these classes. The children were given physical examinations and an effort made to have all physical defects corrected.

The classes met weekly with the physician and were given class instruction in food values and hygiene. The children were weighed and measured each week and a weight chart was kept for each child.

Parents were induced to attend the classes, and when the co-operation of both parents and the children was secured, the gains made by the children were almost startling.

The work, though just emerging from its initial stage, has been satisfactory in its educational value to the child, and has been instrumental in "spreading health influence" throughout the schools in which nutrition classes were conducted.

In contrast to this pre-industrial group is the one composed of children who have broken their school connections and who have applied at the Bureau for working certificates.

This group of malnourished children has been handled in quite a different manner, in an open air school and a vacation camp. The open air school was established by the Arden Shore Association through the interest and influence of the Elizabeth McCormick Fund in November, 1919.

THE ARDEN SHORE CAMP

The Arden Shore Association provided a staff consisting of a Resident Director, Nurse, Play Instructor, Housekeeper and house servants. The Board of Education provided two teachers and one of the Assistant Medical Examiners was the Medical Supervisor, visiting the camp once every week.

Located at Lake Bluff amidst ideal surroundings, Arden Shore gave to a group of undernourished boys the advantage of a scientifically managed school on a par with some of the best private schools. There the boys enjoyed a wholesome home life, receiving at the same time instruction in healthful living.

The boys made gains in their efforts to become physically fit for industry far in advance of our expectations. From the apathetic, uninterested, half-starved, neglected boys who were sent there, there returned to us boys full of life, animation, and ambition, with a real desire to make a success in life. In a number of instances the transformation was almost unbelievable and in our contact with the boys

after their return, we have found this spirit has lived even after their return to their former environment. No complete estimate can be made of the splendid work accomplished there.

The Arden Shore Association in connection with its summer outing work cared for twenty undernourished girls—applicants for certificates.

The Forward Movement Association opened a camp for boys at Saugatuck, Michigan.

Many of the children selected for camp had defects and handicaps of a pathological nature. There were a number of children with closed glandular tubercular glands; several cases of incipient pulmonary tuberculosis; orthopedic defects, some having tubercular histories. There were also cases of retarded development, both mental and physical, some due to inherited syphilis and others due to disturbances in glandular secretions. There were a few cases of low grade cardiac disease; a number of these cases have recently been discharged from hospital care and nearly all have brought their weight up to normal and have gone to work or back to school. A larger per cent of this group returned to school than of any group under treatment.

THE WORK, EDUCATIONAL

These nutrition groups lead one to believe that this work must be educational. Its key note must be instruction in proper habits of living, including regulation of diet, proper way of eating, with periods of rest, recreation and exercise; and personal hygiene.

Secondly: The cooperation of the child; his interest and help are absolutely essential. Practically all failures have been due to lack of cooperation on the part of the child.

Thirdly: The fullest benefit from nutrition work necessitates the correction of defects and of abnormal physical conditions which delay normal development of the child.

Fourthly: The children who have started work and who have kept up their program have continued to gain; though progress has been much slower than during the periods in the school or that preceding their employment.

CLINICAL COOPERATION

The Chicago office has always had splendid cooperation from all existing clinics and dispensaries. This year we have had several new ones. The most important one is an Industrial Clinic for Children, separated in every way from the adult clinic, at the Central Free Dispensary. The clinic meets on Tuesday evenings at half past five. The children in the nutrition class go there directly from work and are given their supper at a cost of ten cents. The children who go for treatment and medical care meet at 6.30 and 8.00 P. M.

The second industrial clinic is at the Mary Thompson Hospital and meets every Tuesday evening at 6.30 o'clock.

In these two evening clinics the greater part of the follow-up work is done. We hope in time to be able to obtain a very definite knowledge of the physical effects of industry upon children and the kind of work that can be best undertaken by children who need medical supervision.

Wesley Hospital also conducts an evening clinic for industrial children.

There is this year in addition to the Cardiac Clinic at the Central Free Dispensary one at Wesley and one at St. Luke's Hospital to which children are referred. Both clinics are under the direction of well known heart specialists.

Additional nutrition clinics have been opened during the past year at the Michael Reese and Wesley Hospitals and at each one of the Municipal Tuberculosis Dispensaries. This has been of great service as it provides better opportunities for sending children to nearby clinics, saving both time and carfare for them.

In connection with the Industrial Clinic at the Mary Thompson Hospital, the department has been given the use of four free beds, which is a very great help in aiding children whose parents are not able to afford hospital care. Every hospital gives a marked reduction in rates to working children.

At St. Luke's many of our handicapped children have had free X-ray treatment and photographs, and in some cases were given corrective apparatus as well as free treatment over a long period of time.

VOCATIONAL SUPERVISION

During the past year the Vocational Supervision League paid the salary of a worker to look after the physically handicapped children who applied for employment certificates and who need special care.

Since the 16th of February, 102 handicapped children have been referred to this worker by the medical department. Most of these children are so physically handicapped that they cannot receive certificates at all under the law. However, they can be brought up to a better physical standard. This special worker sees that they receive the medical attention needed. She adjusts the family situation to enable the child to get further education; she refers the child to the school where he may get special training; she provides a scholarship if necessary; she secures employment for those physically handicapped children who need special assistance in finding work that will not require too much physical strain or that may be done by a child who is crippled.

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Ancient Health Publicity

ONE of the "best sellers" of a period extending from the thirteenth to the seventeenth century was a book on health—the Regimen of Health of the University of Salerno. Sir John Harrington, a gentleman of Queen Elizabeth's court circle, translated this Latin doggerel into English, and another translation was made by Thomas Phayre, who wrote the first book in English on the nursing care of the child. It is interesting to realize that health propaganda by means of pamphlets and books is not at all modern. We have proof of a campaign against infant mortality in Rome in the second century, and it is not unreasonable to believe that people should in all ages have been eager to learn how to preserve their mental and physical vigor. Popular treatises on health seem to have always enjoyed a wide circulation. Harrington in the introduction to his book "The Englishman's Doctor," warns his readers that "There are no drugs here fetched from Mexico," and after deprecating tobacco as "smoak",

"Which English gallants
buy, themselves to choake,"

ends his introduction with a "slogan" which would do credit to the most modern publicity man:

"Go, tell them what thou bringest
exceeds the wealth
Of all these Countries, for thou
bringest them health."

Interest in health matters is only secondary to interest in life itself, since self-preservation is a natural instinct. The "modern" editor who is just beginning to realize that people are interested in health matters might have learned something to his advantage from a study of his prototype of the thirteenth century.

Sound Health Standards

An important field of child hygiene which has received comparatively little attention up to the present time is that which deals with physical standards for entrance into industry. The health of children is becoming more and more an object of care and solicitude while they are in a school, but except in rare instances, efforts to insure health and vigor to growing girls and boys cease abruptly as soon as the child leaves school and goes to

work. Yet it is just at this time that irreparable damage can be done to the girl's or boy's rapidly developing body. Fortunately, this damage can be prevented.

Before receiving a certificate to work every child is now required in eighteen states to be examined by a physician and to be declared "of normal development", "in sound health" or "physically able to perform the work which he intends to do", or all three. But even in these eighteen states the physical standard is the most difficult to enforce of all standards for children entering industry, because it is so poorly defined.

When the law requires that the child shall be in sound health, examining physicians are in great need of a standard by which to determine what constitutes sound health. Standards vary widely from State to State, and even from city to city. When the law requires, further, that the child must be of normal development for his age, examining physicians are puzzled as to just what is normal development for children of different ages. Some of the laws provide also that the child must be physically fit for the work which he intends to do. In England, the certifying physicians study at first hand the occupations, for which they certify children, but in no State in this country does the law make provision for a scientific study of occupations, either by the examining physician himself, or by anyone else. Hence, as studies of the administration of child labor laws made by the Federal Children's Bureau have shown, physicians examining children for employment certificates seldom know enough about occupations to say with authority whether a given child should avoid a particular occupation or whether he may engage in it without injury to his health or development.

Uniform standards for the use of examining physicians in determining physical fitness and normal development are urgently needed to enforce intelligently the physical requirements of child labor laws already in existence, as well as to call attention to the necessity for scientific investigations of the physical effects of different occupations on the developing child as a basis for future legislation. Recognizing this need, and in response to a request from physicians in close touch with children about to go to work, the United States Children's Bureau in 1919 appointed a Committee on Physical Standards for children entering industry. An account of the work of the Committee, which is doing pioneer work in this important field of child hygiene, is given elsewhere in this issue of MOTHER AND CHILD in an article by one of the Committee, Dr. Emma McKay Appel, Chief Examiner of the Chicago Vocational Guidance Bureau.

The Day Nursery

The history of the development of the word in French which cor-

responds to our word day nursery is interesting. "The French term 'creche', developed from the old high German 'krippka', originally meant a manger for animals; specialized to mean the birthplace of Jesus; specialized still later as an asylum for foundlings; later as an asylum for infants of the poor during the time the mother is absent at work." We have gone on from the stage when the good neighbor "minded the children" during the mother's absence, to the day of national associations of day nurseries which aim to set minimum standards of efficiency in the organization of day nurseries.

These standards as outlined at the National Conference of Social Work in 1919, provide for the hygiene and equipment of the day nursery and the motives underlying the question of right admissions. The secretary of the New England Center, Miss Caldwell, said: "The first step in practically applying our standards is a right social diagnosis of the problem—and finally a sympathetic understanding, summing up and review of all the information gathered and a definite reason based on this for the granting or refusal of help—this action not to be an end in itself but a starting point for active constructive, follow-up work."

Miss Caldwell closed her remarks by saying: "Like all progressive social agencies, we have as an ideal our eventual elimination and a chance for every mother to stay in her home, but until the social evils which brought us into existence have been wiped out by more vigorous community pressure, we must still exist to help meet family problems which can be solved by the day care of children."

Health Assurance

Expenditures for the care of those suffering from mental diseases alone in the United States are only equaled by the immense sums we pay out for public education, and Treadway (in International Clinics) asserts that even many forms of mental disease could be prevented if proper environment and mental training of the young child had been provided.

The United States is losing millions of dollars every day from the diminished earning and producing capacity of its thousands of mental and physical defectives. The only practicable way to salvage this loss is by means of a nation-wide campaign of child welfare and child hygiene work to prevent the large percentage of these preventable defects. European countries are alive to the necessity for this type of health assurance, and in spite of lowered credit and depleted treasuries, are appropriating money and giving earnest thought to child hygiene work as an important phase of social reconstruction. Are we to disregard the lesson of the draft system in its application to what is perhaps the most important single problem of our national life?

The News in a Nutshell

What the Papers Say

Nutrition Lessons

IN Utah *a course of twelve lectures on nutrition* and other subjects relating to child care will be given by Dr. Caroline Hedger, of Chicago, at a "farmers and housekeepers' roundup," in Salt Lake City, beginning January 24. The meeting is under the auspices of the University of Utah. (Jour. Am. Med. Assn., 1-15-21.)

The Massachusetts Department of Public Health has published a Nutrition Number. In addition to general articles on nutrition of school children and reports of work in Massachusetts, it contains suggested health plays and health games, and a bibliography on school lunches, food and nutrition. (The Commonhealth, July-August-1920.)

Posture

"A League to Improve Posture." Digest of an article in Modern Medicine, December, by Harry Ling Taylor, on the work of the American Posture League, an organization of educators, hygienists and physicians, formed in 1913. (Literary Digest, 1-22-21.)

In order to direct more attention to the problem of correct posture among children under its care, the Baby Hygiene Association of Boston has arranged for cooperation with the Boston School for Physical Education. Classes are held each week at the Baby Hygiene Stations and children who show signs of postural defects are given individual and group exercises to correct them. Slight defects are noted and corrected before they become serious enough to require hospital treatment. Home instruction is given by nurses and dietitians in order to interest the mothers. (Boston Medical and Surgical Journal, 1-13-21.)

Legislation

"A Tentative Outline for Maternity Protection Legislation." By Irene Osgood Andrews. An outline intended as a basis for State legislation, designed to meet the recommendations of leading authorities of the world and to stimulate State action which is a necessary complement of the Federal bill for the protection of maternity and infancy. (American Labor Legislation Review, Dec., 1920.)

"The Sheppard-Towner Bill Lobby." By Dorothy Kirchway Brown, Chairman, Child Welfare Committee, National League of Women Voters.

"Inside Stories About the Federal Departments—The Work of

the Children's Bureau." (The Woman Citizen, January 22, 1921.)

In Nebraska, *the recommendations of the children's code commission* have been embodied in 53 bills, to be introduced in the legislature this winter. Of this number 15 are new and independent acts, six substitute new laws for old, while the remainder are amendments. Among the measures proposed are the following: A law providing for the creation of a child welfare board in each county, to act as the representative of the State child welfare bureau; one providing for an advisory child welfare council; a law requiring school districts where there are ten or more children of school age to maintain nine months of school each year; districts where there are five to ten pupils, six months of school; while districts with less than five pupils must provide six months of school or pay the expenses of the child while attending school in another district. Other measures provide for a bureau of juvenile research under the board of control, to be connected with some State institution, and serve as a clearing house for the study, classification and treatment of defective children in State institutions and those committed to the board of control by the juvenile courts; make clear the status of the juvenile courts and provide for a court of domestic relations. (Lincoln Journal, 1-13-21.)

Baby Welfare Work

In Florida, field ambulatory clinics have been organized to travel throughout the State, thoroughly equipped to care for eye, ear, nose and throat diseases and dental work. Headquarters will be established at the different county seats where clinics will be conducted with the cooperation of the district public health officers. (Modern Hospital, Jan., 1921.)

"Infant Welfare Work in Lowell" is vividly described by Miss Kate Kohlsaat, R.N., the Superintendent of Nurses there. On account of the high infant mortality rate in the city, the Lowell Guild Visiting Nurses Association has placed special emphasis upon its baby hygiene department. Clinics are held regularly twice a week at the Guild rooms, and during the summer branch clinics were opened in two public school buildings with doctors and nurses in attendance. Fully 50 per cent of the mothers attending are French-Canadian or Greek, and nurses have been employed who can speak those languages. The most discouraging feature of the work is that the mothers are allowed to work in the mills during the greater part of their pregnancy and to return to work as soon as possible after confinement. During July and August, 700 babies came under the care of the three nurses employed. Forty-seven clinics were held with an attendance of 1,337 babies. The effect of the work on the mortality rate is notable: In

1903, the rate was 267 for July, August and September; for the same months of 1920, the rate was 113, the lowest for 13 years. Classes in Mothercraft have been organized among the young girls of foreign parentage. A clinic for infantile paralysis cases is held each week, under the direction of an instructor from the Harvard Infantile Paralysis Commission. (Modern Medicine, Jan., 1921.)

Baby Death Rates

In Maine, *a decrease in the infant mortality rate is reported,* which is especially marked in those communities where energetic child welfare or better baby campaigns were conducted. Twelve of the twenty cities materially lowered their infant death rate last year, in some instances cutting it in half. In Waterville, there was an infant death rate last year of 62.2 per 1,000 births, as compared with a rate of 129.3 the previous year. Here a progressive program was followed by the Child Welfare League. (Survey, 12-18-20.)

There has been an increase of three per cent in the baby death rate in New York City since January, 1920, the rate being 86 per 1,000 births as compared with 83 per 1,000 births in 1919. The increase is largely due to economic conditions and bad housing, in the opinion of the Health Commissioner. Dr. Josephine Baker says that "poor housing conditions foster contagious diseases and pneumonia, the immediate causes of death." (New York Journal, January 20, 1921.) (Brooklyn Eagle, December 26, 1920.)

A Huge Tonsil-Adenoid Clinic

A tonsil-adenoid clinic for children of Rochester was opened on January 10, to continue for 30 weeks. The four hospitals of Rochester are cooperating in the work and have fitted up an emergency hospital for the purpose, where 80 to 90 children a day are operated upon. It is estimated that at least 20,000 in Rochester need tonsil or adenoid operations, a large proportion of whom belong in families unable to pay the fee of a regular practitioner. For the latter class of children a fee of $5 will be charged and these cases will be cared for first, while children whose parents are able to pay more will be listed for later treatment. The children are brought to the hospital the night before the operation, where they are cared for by nurses, and a motion picture show is presented to provide cheer. (Rochester Times-Union, 1-8, 1-11-20.)

Infantile Paralysis After-care

The Committee on After-Care of Infantile Paralysis Cases has published and distributed a report entitled "The Survey of Cripples in New York City." Copies may be obtained from Robert Stuart, Director, 69 Schermerhorn Street, Brooklyn, N. Y. (Jour. Am. Med. Assn., 1-1-21.)

The Foreign Field

The English-Speaking Congress on Infant Welfare

England

The English-Speaking Congress on Infant Welfare

MISS Halford, the Secretary of the National League for Health, Maternity and Child Welfare, in London, has recently written to Doctor Shaw, President of the American Child Hygiene Association, to announce the forthcoming Congress. Miss Halford writes: "We have now definitely decided to hold our second English-speaking Congress on Infant Welfare, in London, on July 5th, 6th, and 7th, 1921. We feel that the time has come when perhaps more good may be done by holding such a Congress as this, than by attempting, in the present state of affairs, to organize a fully international congress.

"We hope very much that our colleagues in the United States will cooperate with us in making this Congress a success, and will find the date selected a convenient one. We fixed upon that date because the first week in July is the time during which, for the last four years, we have celebrated our National Baby Week. We think that our Congress will make a very fitting National Celebration, to be followed up subsequently by local celebrations throughout the country.

"With regard to the programme, we suggest dealing with the following subjects, among others:

(1) Residential provision for mothers and babies;

(2) Inheritance and environment as factors in racial health;

(3) The supply of milk; its physiological and economic aspects."

France

Pen Pictures of Nurses' Work

MRS. Mary Breckinridge, R.N., Director of the Child Hygiene and Public Health Nursing of the American Committee for Devastated France, writes from Vic-Sur-Aisne, on January 6, 1921, enclosing her report issued for the quarter ending September 30, 1920. The following extracts are taken from this report:

"We have fully organized and well developed nursing centers in Vic, Blerancourt, Anizy, Coucy, the county and the city of Soissons, we are placing a nurse at the sixth center of Chavignon, just acquired by our Committee, and we have taken over recently a British nursing unit in collaboration with the city of Rheims—making a total staff maintained by the American Committee of eighteen graduate public health nurses—French, British, and American. The people who have passed under our care in the Aisne since the beginning number 6,296

souls, of whom 371 were expectant mothers and 4,995 little children.

COMMUNICABLE DISEASES

"We are handling all forms of generalized public health nursing, including bedside care of the sick of all ages and conditions and, as local health officers under the departmental Board of Health (Service de Sante) we are responsible for the nursing, disinfection, and suppression of communicable diseases whenever reported to us by doctors or the Board of Health. Tuberculosis suspects and contacts we take into the Rockefeller Tuberculosis clinics for expert advice and we give their excellent British nurse at Soissons, Miss Gilchrist, a car for her follow-up work when she comes into our rural counties to visit the patients we referred to her.

SCHOOL NURSING

"We go into every school in our territory of nearly 100 villages and Soissons twice a year for weighing, measuring and a medical examination for each child, and the wrong conditions noted are remedied so far as lies in our power. The special nutrition of undernourished children has been assiduously kept up. Summer, like winter, finds no let-up in the things one has to do for the school children. The growing interest of the French in school hygiene is helping us immensely, as does also the work of other departments of our Committee in developing games and physical exercises.

BABY HYGIENE

"The school work will always be absorbing but I think that if a survey were taken of our innermost hearts as nurses, it would be found that our deepest interest lay in the baby hygiene. We aim to see everyone of our 749 babies at least once in two weeks and our nurses' consultations are planned so as to include each village that often, (though of course the feeding cases and the sick are seen oftener than that) and there is a weekly consultation with a doctor in attendance at our largest centers. To all baby clinics in all of our rural centers come also the youngsters of preschool age and to make them feel at home we have a lot of washable toys which have been bought with special funds. Ten dollars equips a dispensary with a large wooden horse, a celluloid doll hygienically clothed, and covered in a crib, and a number of wooden and rubber animals. Psychologically, their presence in the dispensaries is beyond all price and our little ones, whose lives have been robbed of pleasure long enough, come to us gleefully and have the time of their lives with the animals or putting the dolly to sleep while awaiting their turn.

PRE-NATAL NURSING

"Next to the baby work in importance comes the pre-natal. These young mothers, old before their time from the ravages of war, need all the help a trained nurse can

bring them and we never forget that with them as with the babies it is the race itself whose welfare we are seeking, its amelioration, its progress, its security."

CONVALESCENT CHILDREN'S HOME

Miss Walker, co-director with Mrs. Breckinridge, says of this home:

"Perhaps the thing of most immediate consequence which we have done was to send a number of our debilitated children to a convalescent home, in Bouillay-Thierry, for two months. The results have been marvelous, not only physically but morally. The influence of Bouillay will permeate their lives, and spread to those who never saw the chateau, for our youngsters are never done talking about their experience there and showing their friends and relatives how certain things should be done."

COUCY

In describing another piece of work Mrs. Breckinridge says:

"Coucy is the only one of our rural centers about which it is necessary to write specifically and that is because from a nursing standpoint it is new. It depended upon Blerancourt for its visiting nursing until early in the last quarter when the pressure of her own work was all the Blerancourt nurse could carry and I took it over as a side issue pending the time when we could have a nurse to develop it as it deserves to be developed. I have only had Fridays to spend there, but so great has been the response of the people, due largely to the work of the Blerancourt nurse, Mlle. Dumon, before me, that 189 visits, of which 147 were from children and the balance mostly from expectant mothers, have been paid me at our temporary dispensary on the thirteen Friday mornings I have spent there, while I have been called upon to make 130 visits in the afternoons. Now Mme. Forsan, of the Florence Nightingale Training School, is taking over the work as a full time nurse in residence, the local doctor, with whom we have been cooperating, is engaged for our weekly baby clinics and a trim little three room dispensary is just built and equipped. Coucy is fully organized, in other words, and with its eight shattered villages nestling around its gorgeous old ruin of a medieval castle, makes a center as interesting as it is picturesque."

SOISSONS

"The work in the city of Soissons deserves more than a passing word. Miss Walker made it her peculiar care and developed it with extraordinary success. The following is from Miss Walker's report:

"We continue our cooperation with the splendid French milk station, the Goutte de Lait Soissonaise, by furnishing nursing service and transportation for their milk, a distance of 12 miles, and we are further cooperating by loaning our dispensary and giving nursing service to the Baby clinic."

"In doing work like ours there is nothing more conducive to success than to have our aims understood

and to have good cooperation between us and those with whom we come in contact, and every day brings us fresh evidence that this spirit exists in Soissons with those women, who have been the leaders in advocating and advancing the welfare of their town against all odds in the past, with the Mayor and his admirable city government, or with the humblest mother our nurses have helped in rearing her child.

EXPRESSIONS OF APPRECIATION

"I have just opened a letter from a mother in which she says: 'Thanks to the good care of your gracious nurse and the excellent powdered milk which you have been giving me I have saved my little girl.' Letters or incidents like these could be multiplied. Take the example of Sister Marguerite of the Order of St. Vincent de Paul, who cares for the old people in the city, and refers the sick to our nurses so that we may visit them; or of the priest who has been for twenty-two years in one village and whose influence is paramount there, who announced from his pulpit that he wished the mothers to take all babies and young children to the nurses' consultation and explained that they must go even though they were well, in order to keep well. Take the incident of the garde-champetre or village crier, who refuses the usual fee for announcing the nurse's projected arrival because he, too, wants to do his bit for the babies; or the military officer who stops his car when he sees a nurse at her work to inquire what she is doing and then thanks her in the name of France, with a genuine ring of gratitude in his voice. Very precious to us always is the understanding of the doctors who see that in the new thing we are constructing we are not trying to supplant them, but to work with them and under their orders. This was well illustrated the other day when a little girl was brought to us with a broken arm. The nurse put on a splint and sling before sending her to the doctor's office, and later the doctor called her up to congratulate her on the way she had applied the splint and to tell her that she had averted a compound fracture. As we go from street to street in Soissons or from village to village outside we are amazed at the reception and response we get from one and all and we are grateful and very humble, for it is our privilege to have the opportunity of working side by side with a people, who, with a marvelous courage, have borne and are still bearing what to us seems to be more than their share of sorrow and discomfort.

"The statistical sheet will give the record, but the advice and help given to the mothers, the sympathy and brightness brought into lives and the inspiration gotten from them cannot be tabulated except in the hearts of the people."

The quarterly report from Mrs. Breckinridge gives the following conclusion:

"When all is said and done we have found, as district nurses al-

ways end by finding, that our best preventive work has grown out of the actual bedside nursing we have given the sick in their homes. It is in times of anxiety and strain that one gets close to people and the help so sorely needed then lays the foundation of trust which makes all things possible afterwards. The family which sleeps with open windows now is the one whose three year old boy we nursed through pneumonia last winter. The mother who consults us about her daughter's baths is the one whose same little daughter hung between life and death with typhoid, for whom we did everything until we had taught the mother how to do it. The baby who never misses a consultation is the one over whose bedside we hung when it was a feeding case at the lowest ebb. After such hours lived together we are welcomed as friends and our counsels do not seem like an intrusion. Today in France, as in America, and even as in Galilee nineteen hundred years ago we answer that immemorial appeal, foreknown before the foundations of the world, 'I was sick, and ye visited me.'"

French Efforts for Repopulation

Homer N. Calver

TWO and a quarter million francs have recently been distributed in France, as prizes to large families. This is the latest manifestation of the efforts being made in that country to increase population by augmenting the birth rate. Even before the war France was much concerned over her very low birth rate and the war has made her problem still more serious. This cost her not only one and a half million dead, but it is also estimated that there has been an actual loss of two million more by reason of a decrease in the birth rate during the war period. It has also been stated that last year there were 220,000 more deaths than births. As a matter of fact France has today fewer inhabitants than it had in 1870, and this is in spite of the gain made by the annexation of Alsace and Lorraine.

Much has been done to combat this scourge of a low birth rate. Very substantial exemptions in taxes are allowed by the state to families with children. Further aid has been given to large families by the many voluntary organizations which have been formed for this purpose. Their efforts culminated last May when, with the cooperation of the government there was held, by the French League a "National Day for Large Families." This brought in three million francs. Even the Institute (the combination of the five leading academies, including the forty "Immortels" of the French Academy), has studied the problem at length, and many foundations, notably the Carnot and Etienne-Lamy prizes make it possible to reward some large families each year.

Unsympathetic landlords and the present housing shortage do not decrease the number of difficulties in

the way of raising large families. *L'Illustration* of November 27, 1920, mentions some of the financial incentives that have been provided in an effort to offset some of these difficulties. This publication also tells of the recent distribution of the Cognacq-Jay prizes. This is the first distribution of these prizes which are 90 in number and amount to 25,000 francs each. They are to be awarded annually. There is one prize for each of the 90 Departments and it is presented to that family which is the largest and the most deserving. The first distribution was made by the French Academy on the occasion of its annual public meeting at which M. Raymond Poncaire presided. In his address, after praising the generous donors of the prizes, the former president of the republic delivered a eulogy on the French family, on large families in general and lauded that abundance of healthy life in which is the power of great nations and their supreme guarantee of the future. In making the awards, the Academy, at the request of the donors, specially considered those large families which had lost the greatest number in the war.

It is interesting to note that of the 65,000 families in France with nine or more children, not less than 7000 are claimed by the Department of the Nord. This same department also claims forty-one families of fifteen or more children, whereas the Department of Cote d'Or has not more than 400 families with as many as nine children.

In France it is hoped that the example set by Cognacq and Jay will be followed by the Government and that it will appropriate money for large families as their just due in return for their contribution of life itself to their country. This recent demonstration under the high patronage of the Academy may, too, be expected to make apparent to the French people the seriousness of the problem of repopulation. It will doubtless make them recognize the necessity—and the profit—of having many children as they used to have in the old story books.

Milk for Vienna Children

In April, 1920, the Friends' Relief Mission helped secure about 300 cows from Switzerland, which were placed on the various farms belonging to a State Agricultural Society and provided milk during the summer for the children connected with the hospitals and welfare clinics of the city. In September, the Mission increased the number of cows by 265 more, brought in from Holland. The milk will all be sent into Vienna during the winter, for the use of undernourished children certified by a doctor to be suffering from want of food. (Maternity and Child Welfare, Dec., 1920.)

Birth Registration In The United States

REGISTRATION of births in some parts of the United States dates back to Colonial days. No claim is made that all the births of the early period were recorded, but a very large part of them were, as evidenced by the old town record books, many of them still well preserved and carefully written. Our early ancestors in this country appreciated the importance of birth registration and every descendant today, who is interested in his family tree, reveres these old birth records which are so important to the genealogist. But, aside from the value that birth records bear in straightening out family pedigrees, a value not always appreciated by the uninterested, all must admit that such records are an absolute necessity for the proper functioning of our present civilization.

The infant mortality rate is one of the best measures of the healthfulness and intelligence of a community. In what sections then of our country, in what race stocks, and in what strata of our civilization are the infant mortality rates lowest? Where are they highest? How can we answer such questions and take steps to improve conditions unless we have the number of births and the number of infant deaths in all parts of our country? The need of good birth registration is so obvious that its lack of completeness at the present time constitutes a national disgrace. New inventions, new pleasures, and new demands of all kinds upon the attention of the individual have crowded to one side this fundamental of continual progress—birth registration. However, the prospect is brightening, state after state is getting into line, and the goal of good birth registration in the United States seems much nearer today than it did a few years ago.

In 1915 the Director of the Census established the registration area of the United States, an area of 10 states and the District of Columbia, in which the registration of births was believed to be 90 per cent complete. The principal trouble with the other 20 states is lack of sufficient state appropriations to enforce properly the laws. A proper birth and death registration depend upon the state and not the Federal Government, results must be sought by appeal to local pride. If every newspaper would carry in a conspicuous place on the front page the following words: WE REGISTER — PER CENT OF OUR BIRTHS, the reader of these papers would wake up and in short time every state would register 90 per cent of the births and be entitled to admission to the birth registration area.

[Report of the Committee on Vital and Social Statistics, American Child Hygiene Association.]

Recent Literature on Mother and Child Welfare

Book Review

Annotated Subject Index and Order List of Books and Pamphlets, Including Government Reports, on Maternity and Child Welfare in England and Scotland. Published by The American Red Cross National Headquarters, Washington, D. C.

This most useful publication, issued from the National Headquarters of the American Red Cross, is a very full and approximately complete guide to publications in Great Britain—up to the time of its issue, towards the end of 1919—which deal with the great subject of Maternity and Child Welfare. If placed in the library of every health officer and pediatrist, it will obviate the need for searches which would otherwise be tedious and laborious, or for the more likely contingency that work already done would be ignored and redundant effort would be put out.

The contents comprise first, an annotated subject-index chiefly dealing with publications issued by the various official agencies concerned in Great Britain in Maternity and Child Welfare Work; next, a very useful list showing how each separate publication may be ordered; and finally, an index of the main subjects dealt with in the main body of the volume.

The value of the index is greatly increased by the carefully summarized notes subpended to the title of each publication, bringing out its salient points. These notes give a most useful clue to the value of each report or volume, and enable the reader to judge with some degree of accuracy, whether he need pursue further his inquiry into its contents.

Incidentally, the volume throws a sidelight on the extent to which the functions of Maternity and Child Welfare administration have been divided among several Government Departments, and gives warning to the American public to avoid similar unphysiological and uneconomic divisions of work.

The volume is not one which lends itself to detailed review; but we hope that it will have a wide circulation and be placed on the library shelf of every one of that large body of official and voluntary workers who are concerned in the scientific investigation of Maternity and Child Welfare problems.

The American Red Cross is to be congratulated on the issue of the index.

—Arthur Newsholme.

[Note—Copies of this pamphlet can be procured, free of charge, on application to the Department of Health Service, National Headquarters, American Red Cross, Washington, D. C.]

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Take the Best Care of Baby's First Teeth So That The Second Teeth May Be Sound

Miss Howell, the Church nurse of the Community House, Springfield, Massachusetts, cut this picture out of a newspaper and pasted it on a card, to teach the parents the need of taking good care of the babies' first teeth.

MOTHER AND CHILD

A Magazine Concerned With Their Health

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Child Health in Framingham

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THE Framingham Demonstration was not, in its original concept, primarily a complete Health Demonstration; neither was it planned as a Child Health Demonstration. Still, tuberculosis is so wide-spread a disease, its study and prevention are so inter-linked with the general health problem, the disease so extensively affects all age groups, that the scope of the Framingham program has inevitably tended to broaden into a program touching most phases of community health. Perhaps this expansion has been particularly obvious in the direction of infant and child health work. Hence considerable attention, has been given, directly or indirectly, to the problem of child health by the Demonstration itself, or by the local cooperating agencies.

We cannot here touch on many of the interesting research activities* carried out in this age group, including the von Pirquet tuberculin survey of children from one to seven years of age; the tuberculin survey of cattle supplying milk to the children of Framingham; the examination campaigns covering large sections of the younger age groups; the research studies on cervical adenitis; and so forth. Rather, there will be related simply those practical activities to insure child health, which have been carried out on the basis of research findings.

It must be remembered that one reason why Framingham was selected was because the number of children, particularly in the schools (about 3,000), constituted what was supposed to be a logical and workable unit for health work. Further, there was every assurance of cooperation on the part of those officials having in charge the health of the younger groups in the population, an assurance most generously fulfilled. The chief activities undertaken in Framingham may be

* See special monographs, reprints, and other publications available at the Community Health Station, Framingham, Massachusetts.

An old abandoned fairgrounds building used as a camp—with a wading pool nearby.

summarized under age group headings—Infant Life, School Life, Industrial Period.

INFANT LIFE

An Annual Birth Canvass—This with the most earnest and persistent efforts on the part of the Town Clerk, has helped to build up the practice of birth registration, until at present from 97 to 99 per cent of all births are registered annually.

Clinics and Nursing—Framingham with a scattered population of about 17,000, has seen the growth during the past four years, of one summer clinic into four all-the-year-round clinics with two nurses and three part-time clinic physicians, attending to pre-natal, infant, and pre-school work. This machinery, first built up by the Demonstration, was for a time carried by the Civic League of Framingham, and is now entirely in the hands of the official town health authorities. It involves an annual expenditure of approximately $3,000. Certainly, no less equipment could be considered adequate for a population of 17,000 people.

Educational Work—An extensive baby week under the auspices of the Woman's Club; a clean and dirty cow demonstration, by the

Board of Health; the publication of letters dealing with infant health problems; special literature; window displays; talks to mothers; moving pictures; and so forth—all of these routine meaures have been used to develop an interest in infant hygiene.

Milk Improvement—From the point of view of tuberculosis prevention, a safe milk supply is essential, and for that reason, a successful effort has been made to increase the percentage of either pasteurized milk or milk from tuberculin tested cattle. It was found that 33 per cent of the children between the ages of one and seven years showed a positive von Pirquet reaction, and that 20 per cent of the cattle supplying milk to Framingham gave a positive reaction. Consequently, special efforts have been made to cut off this possible source of early tuberculous infection.

A Children's Summer Camp—During the past four years, this camp has provided recreation and hygiene for several hundred children in Framingham, ranging from three to twelve years of age. The routine requires thorough examination on entrance and discharge; constant daily medical and nursing supervision; a careful selection of the children in order to pick out those most under par; a thorough follow-up for the correction of defects; and so forth. (The camp work is fully described in Framingham Monograph No. 7.)

SCHOOL LIFE

Medical and Nursing Work—At the beginning of the Demonstration, a part-time physician and one nurse were provided for the 2,500 school children under high school age, at an expense of $1,200. The community, under the direction of its School Committee, is now spending approximately five times that sum, which provides full-time medical service, or its equivalent on a part-time basis; one nurse, two part-time dentists, one dental hygienist, one physical educator and posture teacher, some dietetic work, a dental clinic, some nose and throat corrective work, and so forth. From the tuberculosis point of view alone, the thorough examination which this machinery is able to provide for each child annually, is extremely important. During the first year of its operation, eleven cases of tuberculosis and sixty-nine suspects, together with a great many other defects and diseases, hitherto unknown, were discovered and treated. Open window rooms, school lunches, and similar activities are being developed.

A Nutrition Class—This class is part of the camp follow-up, providing for from forty to fifty children, who are visited in their homes; brought together regularly for weighing, and for instruction; and to whose homes a dietitian is sent when desirable and feasible.

Educational Work—This has included the extensive use of health letters (see Monograph No. 8); the Health Crusader movement in the schools; the development of permanent health clubs as a part of the school routine; talks to children; and visits from Cho Cho.

Diagnostic Standards in Tuberculosis—A special committee of experts has prepared for the Framingham work a set of Diagnostic Standards, which have been distributed widely among physicians in Framingham and elsewhere, to aid in the diagnosis of pulmonary and non-pulmonary tuberculosis in children. Special attention has here been paid to the difficult problem of tuberculous cervical adenitis (see Diagnostic Standards Bulletin).

INDUSTRIAL PERIOD

Medical and Nursing Work—At present approximately 70 per cent of the industrial population of Framingham is provided with full or part-time medical, nursing and clinic equipment and personnel. Compulsory examinations for new employment are required for about 60 per cent of the industrial population, and in the largest industries, special efforts are made to provide instruction classes for the younger workers in the problems of personal hygiene, posture, and so forth.

Education—Lectures, health letters in the local press and other means have, of course, been employed to encourage the practice of industrial hygiene, particularly among the younger employees.

Much of this work has been recently organized, and much is still inadequately executed and poorly correlated with other activities. Practically all of it, however, is now being carried out by local Framingham agencies, and is no longer a direct obligation of the Demonstration as an outside activity. Aimed primarily at tuberculosis detection and control, this program should eventually be reflected also in the general improvement in the health of the infants and children. Indeed, its effect may already, to some degree, be measured in the mortality records.

The infant mortality rate for the year preceding the Demonstration (1916) was 81 per thousand born. In 1918, with the influenza epidemic, this rate jumped to 94.6, while in 1919, it fell to 69.5, with a slight rise to 75 in 1920, due to an unusually large number of premature deaths, and deaths from other congenital factors.

The clinic and nursing work has proven extremely useful in controlling the more obviously preventable factors in mortality. In 1920, for instance, only 6 per cent of the deaths resulted from gastro-intestinal diseases and only 6 per cent from infections. On the other hand, as might be expected, 63 per cent of the deaths were from congenital factors, 66 per cent occurring during the first month of life. Here, as everywhere, there is a need, therefore, for more attention to pre-natal work, if the general infant mortality rate is eventually to be reduced to a minimum.

Teaching Health to the Eskimo

United States Government Work in Alaska

Emil Krulish

Surgeon, United States Public Health Service, Port Townsend, Washington.

THE Federal Agencies engaged in child hygiene work among the natives of Alaska are the United States Bureau of Education, the United States Coast Guard, formerly known as the Revenue Cutter Service, and the United States Public Health Service. The Bureau of Education operates seventy schools, employs one hundred and twenty-seven teachers, and maintains five hospitals with a corps of seven physicians and eighteen nurses. The Coast Guard has a fleet of vessels stationed in Alaskan waters every summer and has many various duties to perform, one of which is to carry medical supplies, teachers, and nurses to various native settlements which are out of reach of the regular line of steamers. A medical officer of the Public Health Service is detailed for duty on each cutter, whose duty, in addition to

taking care of the personnel of the vessel, is to furnish medical and surgical relief to natives, to inaugurate measures to promote the sanitary conditions in the villages, and to advise teachers in matters pertaining to hygiene and sanitation.

The Act of Congress making annual appropriation for the sundry civil expenses of the Government, directs that the medical and sanitary relief of the natives of Alaska shall be under the direction of the Secretary of the Interior, with the advice and cooperation of the Public Health Service. Under this provision the writer was detailed in 1912 for duty in Alaska to study the diseases and sanitary conditions in the native settlements in order to intelligently and economically inaugurate measures for relief. These studies were carried on throughout a period of three years, during which all sections of Alaska were visited, some time being spent in each native community.

NATIVE POPULATION DECREASING

These surveys indicated that the native population was decreasing at an alarming rate, chiefly from tuberculosis, and that infected tonsils, adenoids and eye affections, including trachoma, were very prevalent among native children. The homes, with but few exceptions, were found to be insanitary and responsible in a great measure for much of the illness, suffering, and high death rate. The remedy advocated to improve these conditions and check the ravages of these diseases was the establishment of well equipped hospitals in native centers; the employment of a sufficient number of competent physicians and nurses; the isolation of the sick; and education of the natives in hygiene and sanitation.

The teachers are the only "doctors" and "health officers" in the majority of the native settlements and they have been impressed with the fact that instruction in health matters is just as essential as teaching the three R's. Teachers and nurses now visit each home in the village to see that good hygienic conditions are maintained therein, and to teach mothers the proper care and feeding of infants, preparation of food, cleanliness and necessity of ventilation. The public towel and drinking cups have been abolished in the schools and individual paper ones substituted. All schools are provided with a medicine chest containing simple remedies and a special medical handbook written for the Alaska school services, explaning the use of the drugs. Lectures are delivered at public meetings on tuberculosis, eye diseases, ventilation, and other subjects relating to prevention of disease; special attention and effort being given to children, as upon them the future of the race depends.

HEALTH AS IMPORTANT AS THREE R's

Pamphlets on the cause, prevention, and cure of tuberculosis have been distributed to pupils throughout the school service, and "How

To Keep Well" cards placed in every home. Various bulletins issued by the Public Health Service on health subjects have been distributed to field workers for their information and guidance. For the purpose of assisting teachers in combating the white plague a special lecture on tuberculosis, adapted to conditions in Alaska, was written. A set of special slides was prepared from views taken in Alaska to illustrate the lecture and make it more interesting, inasmuch as the usual stock lectures and illustrations were found to be entirely foreign to conditions in Alaska.

An Eskimo family posing before their home.

In order to realize what a tremendous problem the Government confronts in trying to reach the Eskimo, we must bear in mind that the area of the Territory of Alaska is about one-fifth of that of the United States, and that the natives are scattered in small settlements, 50 to 500 in number, along thousands of miles of coast line and on the great rivers. Many villages are not on the route of commercial steamers and can be brought in touch with the outside world only during the short season of open navigation of approximately four months during midsummer. The native population numbers approximately 26,000 and is composed of Eskimos, Indians and Aleuts. The winters are severe and the people depend largely on natural resources for food, shelter, and clothing.

MAIL ONCE A YEAR

Having completed this preliminary, the rest of this article will be confined to the natives on the Arctic coast; the stretch of country 500 miles long bordering on the Arctic Ocean between Point Barrow, the most northerly point of North America, and Cape Prince of Wales. This section of Alaska is most interesting, likewise very difficult to reach, on account of the dangerous ice conditions which prevail in the Arctic Ocean. Except for an occasional visit of a trader schooner and the annual trip of the Coast Guard Cutter "Bear," which is specially constructed to withstand the heavy ice, no other vessel is seen in these waters. The "Bear" attempts one trip a year in August, the only month when navigation to these villages is possible, and carries mail, supplies, and medical relief to these isolated people. The writer accompanied the "Bear" on her annual Arctic cruise in 1913 and made an inspection of the natives and conditions in the villages along the Coast.

CHILDREN RULE PARENTS

The natives along this coast are Eskimos, and the population is approximately 2,000; the whites numbering less than a dozen. These Eskimos are a congenial, trusting, sociable, and contented people; they have large families; and are fond of their children to a fault; never punishing nor restricting them, as a result of which the children rule their parents and the household in general. This fact is taken advantage of by Government workers in their educational work; an effort to better the home conditions being made through the children. These people, with few exceptions, are above the average native of Alaska in cleanliness of their persons and clothing, and while they do not measure up fully to the standard of the whites, they are far superior to the Eskimos of the Siberian Coast, an indication of their advancement in civilization.

AN ARCTIC MANSION

The Arctic Coast is a barren, timberless country, and the natives depend to a large extent upon the limited supply of driftwood for fuel and building material. Seal oil lamps are used to some extent for lighting and heating purposes. The igloos, as the Eskimo homes are called, are small in size, necessarily overcrowded, and usually every crevice is carefully sealed during the long winter months in order to maintain a comfortable temperature within. The igloos are made of logs covered thickly with sod. They may be lighted by windows or a skylight, the intestine of the big seal being used for glass. There are usually two rooms; one used as a general store room, and the other, connected by a low tunnel, is the living room, about twelve or fifteen feet square and eight feet high. The entrance into the homes may be by a low door, but more frequently it is through an open hatch in the roof, in order to keep out dogs and

An Eskimo igloo showing the skylight protected by a fence. See the entrance through the roof.

prevent the entrance from being blocked with snow. The furniture equipment usually consists of a small stove, a few dishes, and improvised beds. The board floor serves the purpose of table and chairs; a few of the families own sewing machines and occasionally a phonograph. Recently, some of the natives have been persuaded to install special ventilating flues with an outlet through the roof. During the two months of summer, many families abandon the igloo to live outdoors in ordinary canvas tents. In order to correct a false impression which is very common, I might state that there are no ice houses in Alaska.

SIMPLE COLD STORAGE

The principal food supply of the Eskimos is the whale, seal, walrus and fish. The meat is well preserved in underground cellars or placed in the open on elevated platforms and covered with skins. Wild ducks, geese, and the eggs of Arctic sea birds are also used for food; reindeer meat is eaten to some extent and seal oil is consumed in large quantities and considered a delicacy. From the sale of furs the Eskimos are able to purchase flour, coffee, tea, sugar, canned goods, and other staples, from local traders. The only fruit and vegetables eaten are preserved. The water supply is melted ice or snow and is usually of good quality.

SANTA CLAUS' LIVE STOCK

Hunting, fishing and trapping are the principal occupations of the men, while the women, in addition to their household duties, make the

clothing and footwear for the family. Fur outer garments and footwear are worn the entire year. A large number of these natives are engaged in raising reindeer. This industry was introduced and is encouraged by the Government, for it is not only a most profitable business when properly conducted, but a most healthful occupation. As soon as a child is old enough, he is trained as a herder, and the outdoor life which is required in this occupation, is directly responsible for the healthy appearance of these reindeer herders.

As before stated, the reindeer is a most valuable asset to these people. In life, it supplies its owner with a healthy occupation, milk, and means of transportation on land; and when butchered, the meat is used for food; the hide for clothing and boots, covers for floor and beds, and material for making skinboats, a means of transportation by water.

THE REINDEER INDUSTRY

The first herd of sixteen reindeer was brought from Siberia twenty years ago by the Revenue Cutter "Thetis," as an experiment, to build up an industry among the natives in order to make them self-supporting, and today, over 180,000 deer are owned by natives. In this connection, it may be interesting to note that although around Christmas time, the reindeer, with Santa Claus, plays such an important part in our homes, Eskimo children have no such interest in the animal, for their "reindeer" is the Revenue Cutter which in August brings the good cheer so eagerly looked forward to. Can you conceive the difficulty of keeping out of sight for four months, the presents which will be distributed on Christmas Day?

The climate of the Arctic Coast is comparatively dry; the summers of continual daylight of two months' duration are moderately cold. The winters, however, are long, very cold, and with moderate snowfall; the ground is frozen the entire year and the days are very short while for three months there is constant darkness. The climate, therefore, bears an important relation to existing health conditions, as it is the principal predisposing cause in the dissemination of tuberculosis and other infections among the children, because it confines them to their homes the greater part of each year.

THE SANTA CLAUS SHIP

In making the annual call to each village on the Arctic Coast, the "Bear" anchors about a mile from shore and the trip to the settlement is made in a large rowboat. The appearance of the Cutter on the horizon is the immediate signal for great excitement among the natives, who put on their "Sunday best" clothes and all flock to the beach to welcome the visiting party. After the formal ceremony of greeting, in company with the teacher and interpreter, we inspected the sanitary condition of the village and visited and prescribed for all the

sick who were confined to bed, after which we proceeded to the schoolhouse and held a clinic in the classroom. All children were brought in and given a general examination, special attention being directed to the heart, lungs, teeth, tonsils, adenoids, eyes, including vision, and general physique. Those found defective were prescribed for and arrangements for operation made with surgical cases. Glasses were given to those who had defective vision. In the evening, a talk on hygiene and general sanitation was given in the schoolhouse to the parents. The Eskimo has great faith in the Government physician and with few exceptions, follows the advice given. This method of procedure was followed in each village.

Reindeer and their herder in his boat, made of skins.

SURGERY IN A SCHOOL ROOM

In our surgical work, the schoolroom was utilized as an operating room and an improvised operating table was constructed from rough lumber and covered with blankets. A pocket electric flash light was used as a substitute for the elaborate lighting fixtures that one usually sees in our modern hospitals. The majority of our work was for the removal of adenoids and infected tonsils. One of our major operations was the amputation of a leg for tuberculosis of the ankle joint. The boy made a good recovery and the ship's carpenter made a wooden leg for him. The following year I was told that he was entirely well and was one of the best polar bear hunters in this particular village. Another inter-

esting case was that of a boy with harelip. In order to be under constant supervision, he was taken aboard the cutter and the operation was performed in the carpenter shop. The operation was successful, and on our return from Point Barrow, the wound had healed entirely. It is needless to state that the patient was happy and pleased with the result and his people were surprised to hear him whistle for the first time.

ALASKA'S BENEFACTOR

This most important work of conserving the native population in Alaska, in which the three Government services are engaged, has shown wonderful results, but is entirely inadequate to the demand on account of insufficient funds provided by Congress. The appropriation for medical relief in Alaska for the current year is but $90,000 which is just about one-half of the sum required. For educational purposes, Congress allows $300,000, but if this money is spent for education of unhealthy children, it is wasted and poor economy. The Indians of the States have been fairly well provided for with medical relief, but the natives of Alaska have not been as fortunate, and while we are generously opening our hearts and pocketbooks to the call for relief of children in foreign lands, we should not lose sight of the wants of the little natives in Alaska who are entirely dependent upon us for their health and civilization. Let us urge Congress for a more liberal policy towards our wards in far away Alaska.

In writing anything about the natives of Alaska, no article would be complete without mentioning the faithful and unselfish work of W. T. Lopp, at present in charge of the Alaska School Service, under the Bureau of Education. Mr. Lopp has been engaged in promoting the general welfare of these people for the past thirty years, having started as a teacher in the Eskimo settlement at Cape Prince of Wales. No other man knows the native as well as he and nobody else enjoys their confidence as he does. Mr. Lopp has his headquarters in Seattle, but in order to keep in touch with the needs of the people under his supervision, he makes several trips of inspection to Alaska every year.

The Abnormal Infant

Eric Pritchard, M. A., M. D.*

I PROPOSE to preface my remarks on the subject of the "abnormal" baby, by defining, as far as I can what I understand by this term—I regard a baby as abnormal who so noticeably deviates from type either as regards his anatomical make-up, or as regards his behavior as to require a special environment in order that he may live or remain in health. An abnormal baby behaves in an abnormal manner in the presence of a perfectly normal environment; in other words, he responds abnormally to normal stimulation. If fed normally he may have difficulty in sucking, in swallowing, or in carrying on other of the motor functions of the digestive system, and the same is true with respect to the performance of all the other organic functions, as for instance those concerned with respiration, circulation and so on; any individual function may be imperfectly executed even though the conditions of the child's upbringing may be perfectly normal. In the case of an abnormal baby it is generally necessary to temper the wind to the shorn lamb, and modify the conditions of the environment to fit the necessities of the case. The infant must be specially fed or specially clothed or specially protected in some way or other from the dangers of the environment or supplied with special drugs to increase or perhaps to depress any abnormal excitability of his nervous system. It is naturally difficult or impossible to define accurately where normality ends or where abnormality begins. No two babies are exactly similar in all respects, nor will any two babies, though apparently similar, respond in an identical manner to one and the same stimulus; but speaking in quite general terms, an infant may be regarded as abnormal if it becomes necessary to provide a specialized environment for him.

THE CAUSES OF ABNORMALITY: HEREDITARY, CONGENITAL AND "ACQUIRED"

It is important to be able to recognize in the case of an abnormal infant to what causes his abnormality may be due. It is usual to describe special characteristics, either favorable or unfavorable, as (1) hereditary, (2) congenital or (3) acquired. This classification is not to my mind entirely satisfactory because all characteristics, morphological as well as functional, must be *"acquired"* at some time or other in the life history—phylogenetic or ontogenetic—of the individual. No

* A lecture delivered for the National Association for the Prevention of Infant Mortality. London, November 15, 1920.

characteristic ever arises spontaneously, nor has it existed from all time, it has invariably been acquired as the result of some change or circumstance in the environment at some time or other during the life of the individual or of one of his progenitors; and therefore, in my opinion it is quite wrong in principle to draw a distinction between so-called *"acquired"* characteristics, and those which have developed hereditarily or congenitally. It would, in my opinion, be more logical to distinguish between characteristics or abnormalities in terms of time. Firstly, there are those which have been acquired hereditarily, that is to say, impressed upon the germ-plasm; secondly, those which have been impressed on the embryo or foetus before birth; or, finally, those which have been acquired by the individual after birth. In other words, abnormalities appearing in an infant or a child are not really different in kind. Whether they have been acquired before conception, in utero, or after birth, they are indeed the same in kind, but different in regard to age.

THE ANTIQUITY OF THE CAUSE A CRITERION OF ITS SERIOUSNESS

This difference in age has a very important bearing from the practical point of view, both with regard to treatment and prognosis. Abnormalities acquired hereditarily or congenitally are much more difficult to treat and the prospect of recovery is far less hopeful because they are older than those which have been acquired after birth. The longer a modification or characteristic has existed, the more permanent is it, and the more difficult to change. To take a concrete instance, a baby has convulsions shortly after birth. This may be due to some inherent fault in the germ-plasm, and is consequently to be regarded as hereditary. It may on the other hand be due to some adverse circumstance acting on the embryo or foetus during ante-natal life and causing some abnormal developmental fault in the cerebral hemispheres, such, for instance, as occurs in cases of hydrocephalus. The latter condition we should call congenital. Finally, the condition might be due to some injury inflicted on the brain at the time of birth when it would be called intra-natal, or subsequent to birth when it would be called post-natal. The seriousness of these conditions acquired as they have been at different periods in the life history of the individual is almost directly proportional to their age. There is little chance for the hereditary epileptic, while there is quite a reasonable one for a child who has acquired his misfortune owing to some accidental circumstance after birth unless it be of a serious or extensive character. In view of these facts it is clearly our business, when faced with any abnormality with a baby, to discover whether this abnormality dates from a period antecedent to birth or subsequent to it. I have myself fre-

quently failed to recognize that certain unfavorable symptoms existing in young babies have been due to inherent defects in the make-up of the nervous system of the child and caused by damage inflicted on the germ-plasm. In such cases I have tried various remedial expedients under the belief that the trouble has been due to some fault in the general feeding or management, when all the time the symptoms were referable to defect in the central nervous system, a defect which is innate and irremediable.

THE PREDOMINATING IMPORTANCE OF THE CENTRAL NERVOUS SYSTEM

In dealing with infants we are very apt to forget that no function, whether of secretion, excretion, movement or of any specialized form of metabolism can proceed without the control of the central nervous system. If any part of the central nervous system is damaged or defective, the functions over which this part of the nervous system presides will be defective also, and if the whole of the central nervous system is damaged, all the organic functions of the body will be correspondingly defective. It is quite clear that damage inflicted on the germ-plasm must be represented to a greater or less degree by defects in the whole of the nervous system, and not only in separate and independent parts as in case of damage inflicted on the developing embryo, or on the fully developed child—and hence the seriousness of hereditary defects. We are justified in suspecting serious nervous or mental defect when we notice in young babies that several or all the simple and primitive organic functions are imperfectly performed. It is only reasonable to suppose that if the simpler functions of the nervous system are badly performed, the higher functions concerned in the mental processes will also show defects at a later date when the mental faculties begin to develop. Conversely when we know from the history that there is hereditary defect in the makeup of the nervous system, we should be prepared for eccentricity in the carrying out of the simple organic functions.

Before proceeding to a consideration of the conditions, functional or otherwise, which are peculiar to the abnormal infant, I would like to point out that there must be something abnormal about an infant who behaves in a normal manner if the conditions of his environment are themselves abnormal.

DEFECTS IN STRUCTURE MORE SEVERE THAN DEFECTS IN FUNCTION

When we come to investigate the origin or causes of abnormal behavior in infants, our attention should first be directed towards the discovery of any structural abnormality or mal-formation which can account for the eccentric behavior. If such be discovered, the solution of the problem is simple. On the other hand, if no such discovery be made, it becomes necessary to decide whether the abnormality of behavior is due to some inherent and innate fault in the general

make-up of the infant, or whether it is due to some adverse factor in the environment. If, for instance, we find that a new-born baby who passes no meconium has an imperforate anus, we need not seek further for an explanation.

Degenerate infants and others suffering from various hereditary disabilities often give evidence of slight developmental faults or stigmata of degeneration which may give the cue to some otherwise inexplicable abnormality of conduct. For this reason all infants who manifest abnormal symptoms should be examined very carefully for stigmata of degeneration which affect their external structure. It would be unprofitable here to supply a complete list of the various anomalies of development which distinguish abnormal and degenerate infants. I can only give a few common illustrations.

DEFECTS IN STRUCTURE PARTICULARLY NOTICEABLE IN THE FINISH OF THE EXTREMITIES

Speaking quite generally, it may be stated that slight defects in the final finish of a baby are more noticeable in the extremities than elsewhere. Defects in the anatomical relationships of the fingers, toes, ears, genitals or nose are exceedingly common, and the manner in which the development of the orifices of the body and other complicated or involved parts is carried out gives considerable information and indications of the manner of development of invisible parts and organs. If, for instance, we find that the toes or fingers are webbed, and that the pinna of the ear is of a degenerate type, that the epicanthic folds at the inner angles of the eyes are wide and redundant and that the shape of the hard palate is of abnormal type and the external genitals malformed, it is only reasonable to expect that in the presence of such gross structural defects there will be many other minor abnormalities which will express themselves in perverted function. For this reason the external anatomical relationships should be submitted to a very careful examination.

It is only logical to assume that the causes of abnormalities of structure are the same in kind, though greater in degree than the causes of hereditary and congenital abnormalities of function.

THE CAUSE OF ABNORMALITIES

Up to date we have not been able to explain very satisfactorily those slight abnormalities of structure which are commonly designated stigmata of degeneration, but there are valid grounds for believing that they have been recently acquired by the immediate ancestors and are due to damage to the germ-plasm, as for instance, by toxic substances the products of chronic infective disorder such as tuberculosis, malaria or syphilis arising in the parent. Similar poison acting on the foetus in utero may very seriously interfere with the normal exfoliation of the embryonic rudiments, and the same is also probable of other

kinds of poison such as lead or alcohol.

It is therefore advisable when attempting to solve the problem of abnormal function in the infant in the presence of or in the absence of anatomical malformations or physical stigmata of degeneration, to make careful inquiries as to the possible influence of such injurious agents on the germ-plasm or the foetus itself. The conviction is clearly growing upon us that influences of this kind play a most important part not only in determining malformations and perversions of function in infants who are born alive, but also in swelling the number of abortions, still-births, and premature confinements, and in producing mentally defective infants of the Mongolian type.

The problems of the influences of the mental condition of the mother on the developing foetus, so-called "maternal impressions", raise controversial questions of a very acute character. The popular belief that congenital malformations such as hare lip, webbed fingers or supernumerary thumbs are due to the mother having seen similar blemishes during her pregnancy; in other words, that definite impressions can produce identical results in the child are figments of the imagination. On the other hand, there can be little doubt that disturbed mental conditions in the mother can indirectly produce various disturbances of development in the foetus itself. The *modus operandi* of such influences appears to be connected with the action of internal secretions (excessive or deficient in amount), or of circulating poisons produced in the tissues of the mother and reaching the embryo by the placental route. Either as a cause or as an effect, the emotions are closely connected with certain of the internal secretions, especially with the secretion of the thyroid gland. The internal secretions undoubtedly play most important parts in directing not only the rate, but also the qualities and directions of growth, so that maternal impressions may have most important influences in the determination of congenital malformations, and congenital abnormalities of function.* I cannot say whether it is a coincidence or not, but my impression is that since the war the number of congenital abnormalities which I have met with has undoubtedly increased, and they appear to be associated with the pardonable nervous condition of many of the mothers.

I have already devoted more time than I originally intended to the case of the morphologically abnormal baby so that the time I can devote to the baby who behaves abnormally in spite of the fact that he presents no demonstrable external faults of development, must be correspondingly curtailed. This

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* Editor's Note—This is the author's personal view.

is the more regretable, owing to the fact that to this class belongs the great majority of abnormal infants whom we meet with at hospitals, welfare centers and in our private experiences.

FUNCTIONAL ABNORMALITIES

It is in the first place of fundamental importance to be able to recognize whether the functional abnormality with which we are dealing is due to some hereditary cause, or whether it has been brought about by some mistake or error of management after birth, and this for reasons which I have already stated. In the first place I would preface what I shall have to say on this subject by stating that no action on the part of the infant whether normal or abnormal is strictly speaking "spontaneous". Whatever an infant does, or in whatever manner it may behave, is directly or indirectly the result of some form of stimulation, arising either within itself as the indirect result of some remote stimulation from without, or as is more commonly the case, arising directly from without. Every action is in fact a reflex action consequent on some stimulus which has preceded it, and which evokes it. The stimulus which evokes action is some vibration of sound, or light or other form of energy which impinges on one or other of the organs of special sense or common sensation and thence reaches the central nervous system along some so-called sensory nervous tract. From this central nervous system the passing current is reflected along a so-called motor tract to some organ which can give it expression in action. For instance, the stimulus of light falling on the eye reaches the brain through the optic nerve and is then reflected to the eye lid which closes reflexly and gives objective effect to the whole of this complicated reaction. And so in similar manner do other forms of stimulus act, giving expression in one case to movement, in another to secretion, in another to some form of chemical change.

In order that each stimulus may have its due effect it is implicit that the sense organ on which the stimuli impinge should be normally constituted, and the same is true of the nerve paths along which the currents are carried to and from the central nervous system and of the organ which gives it expression.

Normal stimuli acting through normal nervous arcs give rise to normal reactions. On the other hand, if in any respect the arc is abnormal, the response may be exaggerated, absent, deficient, incoordinated or abnormal in some respect.

When a baby behaves in an abnormal manner, although the environment is normal, in other words, although the stimuli which impinge upon it are normal, there must be something abnormal in some sections of the nervous arc along which the particular stimulus travels. If, for instance, an infant

cannot swallow, or is sick, although the method of feeding is perfectly normal, we are entitled to suppose that there is something amiss with some section of the nervous mechanism which controls the functions of swallowing or of the stomach. Some infants show abnormalities with respect to the manner in which they carry out all the organic functions, some show abnormalities only in certain functions. For instance, cretins who suffer from want of thyroid secretion are slow in all their activities, whereas nervous, spasmophilic infants show exaggerated reactions and overdo all mechanical movements.

In order to simplify as far as possible the understanding of these abnormal activities, I propose to group them in a systematic plan according to the functions they subserve, whether of respiration, circulation or digestion.

ABNORMALITIES AFFECTING THE RESPIRATORY SYSTEM

If an infant fails to breathe and expand the lungs at the time of birth, our suspicions are justly aroused that there is something inherently abnormal about the respiratory mechanisms, for the reason that the particular conditions in the environment which evoke the first act of respiration are common to all new-born infants. In investigating the history of abnormal infants, I invariably ask the question "did the child breathe properly at birth, or was artificial respiration necessary?" Apart from chloroform narcosis and the after effects of twilight sleep, and one or two rare conditions, every normally constituted infant should be able to breathe without artificial assistance. If artificial assistance is necessary, it implies that there is something inherently wrong with the respiratory apparatus or the respiratory center.

It must be remembered that there are many modifications of the respiratory act such as sneezing, coughing, hiccoughing and crying, and these also may show abnormalities in function.

Infants who sneeze, cough, hiccough or cry without adequate or reasonable cause are probably abnormal with respect to the constitution of the respiratory center, if not in other respects also. On the other hand, certain infants fail to develop a capacity for sneezing or coughing, in the same way that older children show an inability to blow their noses—this also shows abnormality.

Incapacity to learn complicated muscular coordinations of this kind suggest some inherent defect in the make-up of the nervous mechanism concerned, not necessarily associated with corresponding defects in other parts of the nervous system, but quite usually so. Noisy and incoordinated types of breathing may be present from the time of birth, one particular type known as *congenital laryngeal stridor,* a stentorous kind of breathing,

occasionally met with in young babies, may be dependent on some anatomical malformation of the glottis, or epiglottis, but according to my belief, more often due to some inherent defect in the manner of their innervation. A somewhat similar noisy respiration occurs when there is imperfect nervous control of the soft palate, such as commonly occurs in snoring, but which may occur in infants when they are fully awake.

ABNORMALITIES OF THE CARDIO-VASCULAR FUNCTIONS

With respect to the cardio-vascular, or circulatory system, I have little to say beyond the fact that anatomical as well as functional abnormalities are exceedingly common. An efficient circulatory system is an important condition of health and essential for our future comfort. The maintenance of a normal temperature is largely dependent on an efficient circulation. So-called chills represent dislocations of the vaso-motor mechanisms, and if they occur in consequence of slight causes, the implication is that the vaso-motor centers are inherently inefficient or badly trained. Neurotic and mentally defective infants show from the very first great instability and uneducatability of these nervous mechanisms; they flush, grow pale, their eyes suffuse, they sweat and their feet become cold on the slightest provocation, while a permanent dilatation of the capillaries of the cheeks—so-called rosy cheeks of health, is one of the very commonest manifestations of circulatory defect. The emotions are closely associated with the activities of the vaso-motor centers and to a certain extent give expression to them. Want of control of the emotions, so characteristic of the feeble-minded is invariably accompanied by other evidence of want of control of the vaso-motor mechanisms.

ABNORMALITIES OF THE DIGESTIVE FUNCTIONS

The digestive system early gives evidence of defects of function, especially in those cases in which the general make-up of the nervous system is innately bad. The newborn infant who shows want of aptitude for sucking,* stands convinced of degeneracy of high degree, for this function is obviously one of our oldest and most permanently ingrained attributes. Incapacity to suck is often attributed to a condition of "tongue-tie". As a matter of fact, so-called "tongue-tie" is itself an evidence of the same inherent nervous defect that gives rise to defective powers of sucking and at a later date to lisping and other forms of imperfect speech. Want of coordination of the movements of the tongue, and especially want of powers of projecting it, leads to an unstretched condition of the frenum of the tongue, as well as to defects in the

* Editor's Note—Lack of power or desire to suck occurs very frequently in cranial hemorrhage of the infant and frequently in premature infants that are normal in every other respect.

finer movements of the tongue which are concerned in speech and in sucking. Infants who show defects are liable to find difficulty in swallowing crumbs or solid particles of food at or about the time of weaning; such an incapacity is always suggestive of degeneracy or at least of defective make-up of the nervous system.

Other abnormalities connected with the digestive system are spasms and perverted actions of the various sphincters which are disposed through the alimentary tract. Difficulties in connection with the entrance of food into the stomach and its exit from it are common symptoms in so-called spasmophilic infants, while dysperistaltic movements of the intestine, wind, colicky pains, constipation and diarrhoea represent other symptoms of the abnormal neuro-muscular control of the alimentary tract. Infants who eventually prove themselves to be mentally defective are peculiarly liable to symptoms of the above kind, and unless the underlying condition is recognized, ineffectual attempts will be made to deal with an incurable state.

ABNORMALITIES OF THE GENITO-URINARY FUNCTIONS

The genito-urinary system presents *"mutatis mutandis"* the same kind of anomalies; that is to say, there is incoordination of its special functions. There is enuresis, painful micturition and difficulty in training in habits of cleanliness and at a later date spermatorrhea is a common symptom in boys.

ABNORMALITIES OF THE NERVOUS FUNCTIONS

I enter upon a discussion of the nervous manifestations of the abnormal infant with many misgivings, since properly speaking, a description of them includes all eccentric behavior no matter to what particular system the latter may be referred; a description therefore of nervous peculiarities covers the whole range of my subject. Sleep and abnormalities of sleep should clearly be included amongst these specific functions of the nervous system and in the abnormal child and especially in the mentally defective child, abnormalities of sleep are particularly common. Such infants are often restless and irritable at night and regular habits of sleep are almost impossible to establish. Neurotic mothers frequently complain of the sleeplessness of their infants—in the majority of instances a case of cause and effect, a veritable *"damnosa hereditas"*. I have frequently been told by the mothers of such infants that what with the constant crying and wakefulness of the infant they feel they will go off their heads unless something is done to relieve the trouble. In addition to anomalies of sleep, there are certain evidences which seem to presage later manifestations of mental defect. Mentally defective infants show considerable indifference to their surroundings, they manifest few *spontaneous* activities, and at times are regarded as happy, contented

babies; they nearly always are extremely nervous or extremely phlegmatic.

Among special symptoms which connote instability of the nervous system may be mentioned twitching of the muscles of the expression, rolling or nodding of the head, swaying or other rhythmical movements of the body, nystagmus or oscillations of the eyes, squint or want of coordination in the movements of the two eyes, asymetary in the movements of the muscles of the expression, an anomaly which gives rise to the sardonic grin which serves as a smile in many a degenerate infant.

The movements and postures of mentally defective infants are very characteristic, speaking quite generally, we may say that they learn slowly and that when learnt all movements are more or less clumsy. A seriously mentally defective infant will at six months of age keep its legs crossed and its thigh drawn up, and it will show corresponding delay in learning how to hold up its head, how to sit, stand and walk.

A normal infant responds to the circumstances of his new environment comparatively quickly. He soon learns how to use his legs and make other so-called spontaneous movements. In this connection I would again remind you that the performance of such movements is in no wise of the nature of spontaniety. All muscular actions owe their origin to external stimuli which reach the central nervous system by way of the special senses or nerves of common sensation. Consequently infants in whom there is any defect of the special senses and who are thus deprived of a corresponding number of external stimuli will show special delay in the development of the muscular system and in the capacity to perform voluntary movements. Infants who are blind or deaf or dumb from birth or shortly afterwards show great delay in general development from their restricted supply of external stimuli. Blind or dumb infants who may be perfectly normal in all other respects often give the inexperienced the impression of being mentally defective. As a matter of fact, if care be taken to provide them with compensatory stimulation through the unaffected senses, they may be made to develop almost as quickly as normal children.

Abnormal infants often show defects in their capacity to maintain regularity of their blood temperature. This is due either to inherent and serious defects in the make-up of the heat regulating centers or to a combined defect in these centers and in the vaso-motor centers already referred to. These centers in abnormal children are often most difficult to educate and train. In this connection I would point out the desirability of testing the temperature of young infants by means of special thermometers which register below 95° F. for not only do degenerate infants often

show falls of temperature below this point or even below 90° F., but occasionally infants who are normal in all other respects do likewise. It is unnecessary to point out that ordinary thermometers do not give evidence of such falls, and if the latter remain undetected, serious consequences may ensue.

Sub-normal temperatures are not, however, the only forms of thermic derangement liable to occur in abnormal infants; instability of the centers concerned may be shown in diverse ways, as in high fevers and wide fluctuations on the very slightest provocation. I have known infants with unstable heat regulating mechanisms who have shown temperatures of over 105° F. during the troubles of first dentition and who have apparently been none the worse for it as soon as the offending tooth has come through the gums.

ABNORMALITIES IN THE MUSCULAR FUNCTIONS

The muscular system frequently gives evidence of the abnormality of the child. I have already stated that the muscles and various muscular coordinations are the chief means through which we can give expression to reflex stimulation or conscious thought. When for any reason there is little opportunity for such expression the muscular system shows defective development. There is no better illustration of this than is to be found in cretins or in infants suffering from serious degree of hypo-thyroidism. In such cases, from want of adequate activation of the nerve cells with the thyroid secretion, the infant is lethargic in its reactions to external stimulation, from want of use the muscles are undeveloped and hypotonic, and the whole of the body shows similar retardation of growth with respect to its specialized tissues.

Within limits, analogous want of muscular development is characteristic of all varieties of mentally defective infants; they are late in learning how to hold the head up, how to sit, stand and walk. The posture of mentally defective infants is equally characteristic, they maintain the flexed and enfoded uterine attitude long after normal babies have relinquished it. The long persistence of the tibial curve of defective infants is due to the crossing of the legs and the flexion of the thighs on the abdomen which represents the maintenance of the uterine posture, and a want of response to the change in the environmental conditions which occurs at birth.

It follows from the above facts that if abnormal infants increase normally in weight, the increment in their weight is due to fat and other forms of undifferentiated connective tissue, and not to more specialized cells. The abnormal infant may show a good weight, but the weight will not be due to sound physiological tissues.

One of the most constant characteristics of the abnormal infant is

vagaries and eccentricities of the weight chart, the latter may show too steep an ascent of the curve, or on the other hand it may be too flat, but whichever direction the curve takes irregularity is a common defect. The normal infant who is normally fed increases in weight to the extent of about six ounces a week, and this increment is practically constant for the first twelve months, so that the curve presents a perfectly regular line throughout the whole of this period. It is interesting in this connection to note that under normal conditions of health, so great is the bias for growth to maintain its normal inclinations that it is not disturbed by temporary fluctuations in the intake of food.

ABNORMALITIES IN THE FUNCTIONS OF THE SKIN

The skin and external integuments of abnormal infants present many pathological stigmata of a functional, as well as of an anatomical order. I have referred briefly to certain of the structural abnormalities that are met with, I propose here to refer to only one or two abnormalities of function. One of the most striking of these is the great tendency of the skin of sensitive or neurotic infants to show weals and markings in response to comparatively mild degrees of stimulation. For instance, it is quite easy to write the child's name on its back by tracing the letters with the point of some blunt instrument. This phenomenon is known as dermographia. Abnormal infants are very prone to develop nettle rash, papules, vesicles or rashes as the result of exaggerated reactions to toxins or chemical substances consumed in the food or generated in the system. This sensitiveness to foreign stimulation is known as anaphylaxis. Some infants are so anaphylactic that the ingestion of foreign proteids such, for instance, as are contained in cows' milk may produce serious symptoms.

ABNORMALITIES MAY REPRESENT EVOLUTION NOT INVOLUTION

In concluding this brief account of the abnormal infant, I must warn you against including in the catagory of degeneracy all infants who do not conform to type. There is such a thing as evolution, which is progressive, and which represents variation which may be a step in racial evolution rather than involution. Anaphylaxis itself, which is by some regarded as a step towards the acquisition of tolerance and immunity to noxious stimuli in the environment, may be an example of this kind. It is only by a very careful observance of the reactions of many infants that we are likely to be able to form an accurate estimate of the degrees of abnormality of any particular baby or whether any particular departure from the usual type represents degeneracy or evolution.

Breast Feeding In Minneapolis

Nathalie C. Rudd, R. N.,

Executive Secretary of the Infant Welfare Society

IN 1920 the Infant Welfare Society of Minneapolis took over the work of the Breast Feeding Investigation Bureau, organized under Dr. J. P. Sedgwick, Professor of Pediatrics, University of Minnesota.

There was a two-fold purpose in undertaking this work; first, to carry the gospel of breast-feeding to every mother in Minneapolis; second, to gather statistics as to the prevalence and duration of breast-feeding among these mothers. This work necessitates the visiting of every new-born baby whose birth report comes to the City Health Department, a second visit to each baby at the end of its second month, and a further following of each baby by circular, (and a visit if the circular is not answered,) until the baby has passed its ninth month. These circulars, when sent out, are accompanied by a stamped return envelope with card enclosed for answers as to the baby's feeding at that time.

At the first call the nurse ascertains whether there is any trouble in nursing this baby, and whether there has been any trouble in nursing previous children. If any mother is anxious about her possible inability to continue nursing, the idea is impressed upon her that the surest way to maintain her milk is to empty the breasts completely and regularly. If there is evidence that the mother is not completely utilizing her milk supply at every nursing, the nurse teaches her how to press the milk from her breast.

If the baby comes to the clinic, a regular social and medical chart is started, with the hope and intention of keeping the baby under supervision through its second year.

After the first call is made and entries recorded, the card is re-

turned to the office, and filed by serial number. Each nurse has entered these cases in her "breast-feeding" book. These books readily show when the second call is due. We feel that this is the most important call, as just at this time we find the mother most liable to discouragement, anxiety, and a prey to the advice of her neighbors. All too frequently she has ceased nursing her baby, convinced that her milk was not the right food.

Report on the second call is made to the office by telephone, the nurse stating that she has a "report on second calls", and giving serial number, date of call, and feeding (by code). The serial number indicates the filing drawer, and the facts are entered on the permanent card as reported, the nurse at the same time checking off her own list. Absolute accuracy here is essential; if the entry is not made permanently in the office at this time, and if the nurse does not check off each reported call, much confusion arises.

In the office a ledger is kept of cases given each nurse (entered before the cards are distributed, by serial number, and the nurse's station only) and her returns on these cases are checked off against these numbers also. In this way it is easy to detect unreported calls or overlooked visits.

The subsequent contacts, through the baby's first nine months, if the baby does not come to the clinic, are by means of circulars. These circulars vary, both in text and in make-up, from month to month, the better to attract the mother's attention.

When one of these babies is admitted to clinic, circularization is dropped for that baby and the facts are obtained through the clinic contact. Out of 1,528 admissions to clinic since January, 1920, 1,042 have come to us through the means of these breast-feeding calls.

RESULTS

So much for the object and the method. As a result we know today, in regard to the 773 babies born in January, 1920, that there were:

	At the close of January	At the close of June
Artificially fed	0	55
Entirely breast-fed	598	436
Artificially fed from birth	28	28
Babies died	21	28
Mothers died	6	6
Refused information	0	1
Moved away	8	55
Cannot be traced	18	70
Out of town cases	58	58
Illegitimates not reported	14	14
Stillborn	22	22
	773	773

Similar facts are in process of accumulation for each month of the year.

SOME OTHER EFFECTS OF THE WORK

In January, our total clinic attendance was 781. In April, it was 1,178; in July, 1,384. The age of the babies being admitted to clinic is on the average much younger than heretofore, 36 per cent being under 2 months, and 62 per cent being under 4 months on admission, of the cases admitted since January. Of the babies under 4 months, 91.5 per cent were breast-fed on

admission. This growth, and the appreciation of the need of early advice as to feeding we attribute directly to the influence of these widespread visits, and the teaching that goes hand in hand with them. Formerly the registration at our clinics represented all the mothers whom we had been able to interest in our work. Now we know that far beyond the confines of the clinic room, the teaching of the value of breast-feeding has gone, and that not a mother of a 1920 baby in our city fails to know our principles:

First, that the mother's milk is best for the baby.

Second, that every mother can nurse her baby.

Third, that lactation may be re-established.

Fourth, that the persistent emptying of the breasts at regular intervals leads directly to further stimulation.

Again it is known that artificially fed babies are much more subject to contagious diseases than those given a start on breast milk. This applies not only to the months when the baby is being actually nursed, but to all the ensuing years. Breast-fed babies develop more resistance for later life.

Fitter Families for Future Firesides

THE value of the periodical physical examination as a constructive health measure has been conclusively demonstrated by Medical School Inspection, by the Children's Health Conference, and by the Life Extension Institute. It is being adopted as a routine procedure by a steadily increasing number of agencies.

The Fitter Families project gathers together these isolated procedures, combines with them approved nervous, mental, and intelligence tests, includes the heredity history and claps this thing on the entire family, instead of confining activity and interest to one isolated member of the family as has been done in all previous efforts, so far as known.

A suitable opportunity did not present itself for trying out the scheme until September, 1920, when Mr. Phil Eastman, Secretary of the Kansas Free Fair Association, tendered to Dr. Florence Brown Sherbon, Director of the Division of Child Hygiene of the Kansas State Board of Health, the use of a building on the fair grounds for a health demonstration.

This building had formerly been used for a commercial exhibit, but lent itself admirably to the new purpose. It was partitioned into eight examination rooms, and fitted out with a simple but sufficient ex-

amination equipment. A sign across the front of the porch proclaimed that this was the "Eugenics Building." Along the ridge pole was boldly painted the legend, "Fitter Families for Future Firesides." Mrs. Mary T. Watts attended to the publicity and material details, while Doctor Sherbon attended to developing a method of procedure, and organized a medical staff.

HOW STANDARDS WERE MADE

Two objectives were set for the first tryout by Mrs. Watts and Doctor Sherbon; first, to work out a technique; second, to establish standards for judging families.

Doctor Sherbon called a conference of specialists, and after explaining the idea, submitted for their consideration the examination forms used by the Life Extension Institute, the Federal Children's Bureau, the Bureau of Education, the Eugenics Record Office of Cold Springs Harbor, and other forms. It is worthy of note that not one physician failed to give not only hearty, but enthusiastic response.* A number of conferences were held, and in the end an examination form was drafted which included ideas from a number of the forms submitted plus the composite ideas of the groups. A scheme of rating was devised also. For the smaller children the regular Child Hygiene Division form was used.

The time required for one adult individual to pass through the entire procedure was about three hours, or one entire half day session. Twenty-five families, numbering one hundred and one individuals, completed the examination, with the exception of five individuals who for various reasons failed to entirely complete the procedure and were given incomplete grades or no grades. In the twenty-five families examined, nine families each had one child, eleven families each had two children, three families each had three children, two families each had five children, one family had also a grandmother who took the examination.

BAITING THE HOOK

Governor Allen offered a silver trophy to the fittest family. Senator Arthur Capper offered a medal to each grade A individual, while the State Board of Health offered A, B, and C health certificates, corresponding in general form to first, second, and third grade teachers' certificates. The awards as granted stood as follows:

Grade A or Capper Medal individuals	55
Grade B or Second Grade Health Certificates	41
Incomplete, or no award	5
Total	101

Three families showed all grade A members and average scores so nearly alike that they were said to tie for first place. Two of these

*Copies may be secured on application to the Division of Child Hygiene State Board of Health, Topeka, Kansas.

families consisted of a father, a mother and one three months old baby each. The third family consisted of a father, mother, a son nine years old, and two daughters of thirteen and eighteen years, respectively. In the opinion of the directors, this family, although showing a total average score a few tenths below that of the two small families, deserved a handicap by virtue of number and age. The trophy family and one of the small size families are farm families. The father of the third prize family is a lawyer.

The originators of the Fitter Families project said to each other: "We are gambling on the risk of the public being ready to receive this idea; it will either be a tremendous success or fall very flat." They thought it best to "bait the hook" heavily in order to get an opportunity to make a demonstration, hence the trophy and medals. The common response, however, was to this effect: "It's a fine idea but you will never get the parents to submit to an examination." The plan was explained through the press and about a dozen families were registered in advance. When the fair opened, the building naturally attracted much attention, and Mrs. Watts spent her entire time on the front porch keeping out the curious, explaining that it was not a free clinic, and telling individuals what it was all about. Many more families and individuals applied than could be accommodated, although an assembled staff of some eighteen specialists and assistants worked like beavers from nine to twelve and from two to five daily. (Incidentally all gave their services gratis.) The gratifying thing to the workers was the fact that the public seemed to be ready for the idea, and that the compelling motive which induced the families to forego the joys of the fair and spend, some of them, a long, tiresome day in this austere building, was an appreciation of the value of a thorough physical appraisal. The awards seemed to be the matter of least interest to all concerned. One farmer drove eighty miles in a Ford with his wife and five children, a lean, brown, alert group. When some one suggested that during an unavoidable wait they go out and see the fair, they said, "We don't care for the fair; we came to get this examination."

INTEREST OF CHILDREN

It was most interesting to note the grasp and zest with which the children from ten to eighteen went through the performance. Each examiner took pains to interpret each person's condition to him as he went along. The educational effect of this in the case of the children can be only surmised, but is doubtless one of the most valuable by-products of the demonstration.

Another interesting fact was the willingness of every adult to take

the entire laboratory procedure, which included urethral smear, Wasserman, qualitative urinalysis, and haemoglobin test. Not a person objected to taking the Wasserman and not a woman manifested any hysteria over the procedure.

The laboratory findings were entirely negative with the exception of one nonspecific inflammatory smear, and one albuminuria in an apparently healthy woman.

The fact that the public grasped the purpose so clearly was a matter of comment and congratulation. Instances were related of a judge and a farmer going through side by side; of the naive comments of the junior members; of two boys about nine and ten who brought a third because he was a runt and they wanted to find out why he was not as big as his younger brother; and so forth.

The public was entirely barred from the building and all windows screened. So great was the curiosity aroused that it took a determined guard at the door to effectively convey the idea that this was not an "exhibit". In each examination room was a high window some six feet from the floor and at least eight feet from the ground. On one occasion an examiner looked up to see a gamin hooked over the sill of her window thoroughly enjoying himself—for a brief moment.

The list of examiners who cooperated in carrying out this strenuous plan gives an idea of the professional response. The local hospitals generously cooperated by keeping a relay of student nurses on duty all the time.

The Fair Association paid all expenses but not one cent was paid for service, except to the janitor.

On the last day of the fair the staff took lunch together and discussed the work of the week. Every one had some suggestions to make as to "how we shall do it differently and better next year", but all agreed that in the main the machine worked very well considering its size and the complexity of its parts, and considering the really pioneer nature of the plan.

It is proposed to repeat the program next year with considerable improvement in the alignment of the machinery of procedure, and a very careful revision of the examination blanks. It is also hoped that it may be possible to simplify the plan for use at county fairs. The educational opportunity which is afforded by the county fair has been too little recognized. It is primarily an educational project designed to transmit information and stimulate improvement in plant and animal husbandry and domestic science. But it likewise affords an ideal opportunity to transmit information and stimulate improvement in matters of human husbandry, a sane and rational application of the important principles of so-called eugenics.

THE CHILDREN MUST BE SAVED

Herbert Hoover

The work of these great associations, the Red Cross, the Relief Administration, the Friends' Service Committee, and Jewish Joint Distribution Committee, and all the others, is a work in protection of your children and of my children. For some time in the future, unless these children are preserved and cared for, our children will be infected by them. These children are the real wastage of the war, this mass of undernourished, underfed, mentally, morally and physically destitute children. Twenty years from now, they will form the basis of civilization of Eastern Europe. They must be saved, and they must be built up morally and physically. It must be done if we are to preserve the foundation of Society in Eastern Europe, and above all it must be done if we are to preserve the love of humanity in the United States. These children are no more my children than they are your children. They are the obligation of every man and every woman in the United States after he has cared for his own children and his neighbors' children. They are a charge upon the heart and upon the conscience of America. The completion of this task is indeed the completion of a great chapter in our national history, a chapter for which our children will remember our generation with gratitude. The abandonment of this mass of children would bring a shock not alone to our national honor abroad, but a shock to those of us who believe in the ideals of the American people, and a shock to our children for three generations. I would rather have the American flag implanted in the hearts of these fifteen million children than flying from any citadel in Europe.

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MOTHER AND CHILD
A Magazine Concerned With Their Health

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APRIL, 1921

Six Months Progress

PERFORMANCE is not always measured by figures and words. In calculating the output of an engine it is quite simple to state its efficiency in mathematical terms. In judging the success of a commercial concern it is easy to draw conclusions from tabulated reports. But in attempting to estimate the influence of an Association in which human beings play a vital part it is very difficult, if not impossible, to convey in so many words an adequate impression of what is actually being accomplished. Seeds sown broadcast do not all ripen at the same time. Warmth of personal touch and stimulus of constructive suggestion count for much in the harvest. Certain lines of effort, however, can be plainly indicated.

The American Child Hygiene Association has now reached the promising age of eleven years—an age when activity and growth should play a large part in its development. In line with its stress upon a full rounded program for child health, and in response to ever increasing demands, the Association is gradually extending its activities. Last year marked considerable extension of its work through personal contacts in the field over a large territory, through the publication of the magazine, and a statistical report on infant mortality, and through cooperative efforts with other national organizations. Membership in the Association expanded to more than twice the number of a year ago. Affiliated societies working out various phases of child hygiene throughout the country increased to the encouraging number of 220.

Since the eleventh annual meeting of the Association at St. Louis, the constructive plans outlined there have gone steadily forward. Our Field Director, in response to many invitations, has covered considerable territory in the Middle West, North Central and New England states. She has been in conference with our affiliated societies in thirty-one places where she has been able to establish much closer relations with them. In these places personal contacts with individuals, groups of individuals, health officers, nurses, teachers, and social workers have been cultivated. The increase in field work has gone hand in hand with the

considerable increase in correspondence carried on from the executive offices.

Much valuable information concerning maternity and child health is daily filtering into the offices of the Association. Through a classified arrangement of this wealth of material it is planned to make it available to all interested. State and local files are kept of all reports and pamphlets coming into the office so as to admit of ready reference. An important function of the Association is to act as a clearing house.

The statistical report on infant mortality in the cities of the United States sent out by the Association last year has received very favorable comment. Requests for it are received almost daily. It has had a salutory effect in stimulating health officers in a number of places to hand in more complete data for this year. Steps have already been taken to gather the infant mortality statistics for the 1920 report.

Another piece of research which the Association has undertaken is the study of the programs of all national organizations carrying on any phase of child welfare work. Last year a digest of these programs was published and distributed to those interested. This year additional enquiries are being made to bring the digest up to date. The Association has also taken an active interest in the formation of the National Child Health Council—a pioneer step in coordinated health endeavor.

The General Director has been called into conference with a considerable number of individuals and organizations interested in the health of the child. Since the annual meeting he has represented the Association at five important national conferences and given addresses before a number of medical societies and health institutes, among which was an Institute for Health Officers at Johns Hopkins University School of Hygiene. A course of lectures on the relation of child hygiene to the general health program was also given to a group of nurses and social workers at Johns Hopkins University. This work is really in line with the educational ideals for which the Association stands.

A most encouraging sign of the life of the Association was the response which came to the statements for membership dues which were sent out in November. By the first of January approximately three-fourths of the dues had been paid. The strength of the Association lies in its membership and affiliated societies. These we must cultivate in every way possible. In order to carry out the program we have outlined, the membership should be greatly increased. Our members can do much to bring this about. We look for their support in helping to secure the 10,000 additional members we should have this year.—Richard A. Bolt.

The News In A Nutshell

What The Papers Say

VITAL STATISTICS IN BUFFALO

Vital Statistics for the City of Buffalo for the year 1920 are published in the Buffalo Sanitary Bulletin of December 31, 1920. This bulletin was received February 3rd and the promptness with which these figures are made available is most commendable. With an infant mortality rate of 104, Buffalo shows a slight improvement over its rate of 107 for the previous year. Over 50 per cent of these baby deaths occurred during the first month of life; 36 per cent during the first week; and 23 per cent during the first day of life. Today 104 is not considered a good record. A few years ago it would have been cause for considerable satisfaction. The average for twenty-four cities of over 250,000 population in 1919, was 85.3 and of these cities, 83.3 per cent were below 100.

The striking thing and, unfortunately, the unusual thing, in such local reports is that these figures may be accepted as an accurate statement of fact. It is a statement without any attempt to dodge the issue. All deaths registered are counted. Non-residents are included. Prematures are included. Stillbirths are recorded separately and are not used to pad the birth rate. This is the method adopted by the United States Census Bureau and is the accepted method among vital statisticians. It is to be regretted that it is not more universally followed. Doctor Franczak is to be congratulated on the promptness and honesty of his report.

ANTI-COFFEE DRIVE

A crusade against coffee drinking by children of the fourth, fifth and sixth grades is soon to be launched by the school health department of Poughkeepsie. In one class, thirty children were found who were drinking a cup of coffee a day, on the average. (Poughkeepsie Eagle-News, 2-18-21.)

COMMUNITY HEALTH LECTURES

HUNTER College, of New York City, has arranged a course of lectures to be given from February to June, 1921, on Community Health Problems. This practical course in social work for the community is designed for men and women of experience who wish to prepare themselves for leadership in community service. Students are admitted only after a preliminary conference with the instructor. The lectures and speakers are as follows: The Importance of Maternity Care, Anne A. Stevens, R.N.; Malnutrition, Charles Hendee Smith, M.D.; Feeding the

Family, Mary Dunning Rose, M.D.; Infant Feeding, Rudolph Duryea Moffett, M.D.; Infant Mortality, Philip Van Ingen, M.D.; Mental Hygiene in Childhood, Edith R. Spaulding, M.D.; The Early Recognition of Mental Disturbance, Edith R. Spauling, M.D.; The Prevention of Deformity in Children, Henry W. Frauenthal, M.D.; Social Service and Children's Health, Abraham Lincoln Goodman, M.D.; What is the Duty of the Community in Preventable Diseases? Louis I. Harris, M.D.

NEW YORK'S HEART CASES

The Board of Education of New York City is making an effort to raise a fund of $100,000 for the prevention and treatment of heart disease among school children of the city. Investigation has shown that there is much cardiac trouble among children; a physical examination of 516 pupils in one of the Brooklyn schools revealed the fact that 9 per cent of them were afflicted with such diseases. (Jour. Am. Med. Assn., 2-5-21.)

CRIPPLE CLINICS

There are twenty-seven permanent clinics for crippled children in Illinois. Because of the need, these clinics are to be held with greater frequency, and there is a demand for full instead of half-day service. (Modern Medicine, February, 1921.)

WASHINGTON MOTHERS STUDY PLAYGROUNDS

The playground needs of Washington schools are to be shown by the publication of a survey of existing conditions, which is being made by a committee of the District of Columbia Congress of Mothers and Parent-Teachers Association. This survey is being conducted by means of questionnaires which are filled out by members of the committee after personal visits to the school playgrounds. Many of the schools have no facilities for recreation except basement playrooms. Pictures which have been made of playgrounds, will be on exhibit at the meeting of the National Congress of Mothers in Washington in April.

The points noted on the questionnaires are as follows: Surrounding conditions (windows, shacks and rubbish); position, (a) which side of the building, (b) shade, (c) unobstructive play space; surface, drainage, equipment; (a) playground, (b) drinking water; nearest municipal playgrounds; available vacant lots in the school districts.

The Mothers Congress is making efforts to have playgrounds already in force and those which may be established, kept open all the year. (The Washington Post, 3-5-21.)

WHAT THE GOVERNORS WANT

A digest of the messages of the governors of thirty-seven states to the legislatures in session is given in Public Affairs Information Ser-

vice Bulletin, for February 12. Among them are the following suggestions for legislation affecting children:

Nevada. The creation of an unpaid, unpolitical commission of men and women to assume either advisory or direct charge of the State penal and charitable institutions, to administer the proposed child abandonment law, to administer the mothers' pension act in cooperation with the county authorities, and exercise general control and supervision of solicitors operating in behalf of organized and private charities in the state.

New Jersey. Legislation prohibiting the engaging in industrial occupations of any mother for six weeks before and six weeks after the birth of her child.

South Dakota. Revision of the mothers' pension law to include nursing, medical and hospital care for needy expectant mothers. Appropriation to the Child Welfare Board for a publicity campaign to stimulate the provision of suitable recreation facilities for children of the state.

MENTAL HYGIENE IN THE SOUTH

A mental hygiene survey of South Carolina, directed by the Child Welfare Commission, is being conducted by Dr. V. B. Anderson, of the National Committee on Mental Hygiene. (Jour. Am. Med. Assn., 2-26-21.)

SASKATCHEWAN'S AID TO MOTHERS

Any expectant mother in Saskatchewan, Canada, who for financial reasons is unable to secure for herself the necessary medical, hospital or nursing aid, or clothing for herself or her expected child, may obtain assistance to the extent of $25 by making application to the Commissioners of Public Health. Such application should be made through the registrar of vital statistics of the district in which she lives and receive his endorsement, or that of someone else in official position. This aid is given only to mothers in rural districts where medical care is expensive because of the distance from doctors. ("Some Saskatchewan Legislation Affecting Mothers and Children." Government of the Province of Saskatchewan, April, 1920.)

HONOLULU HEALTH SERVICE

Medical inspections were made in all but six of the schools of Hawaii during the year ending June 30, 1920, according to the report of the Board of Health. Children found to have physical defects were referred to their family physicians, and those from families unable to pay for treatment received free hospital care. Nearly 40,000 children were examined and over 164,000 treatments were given by public health and settlement nurses.

A large number of children in Honolulu were found to be suffering from malnutrition and through

the efforts of the Women's Committee on Child Welfare, school lunches were established. Special care is given undernourished children on the islands of Maui and Kauai. (Report of President of Board of Health, Hawaii.)

In Honolulu social service workers from America have maintained the Palana Settlement House for twenty-five years. Among the results of its work are a health service in the schools and playgrounds in various parts of the city. The settlement maintains a staff of visiting nurses, a free dental clinic, milk stations, and a dispensary for city and country, a tuberculosis camp and a country camp for mothers and infants. (Survey, 2-5-21.)

BABY CARE TAUGHT TO GIRLS

A course in baby care is given the girls of the Lucy Flower Technical School, Chicago. An exhibit marked the close of one course, recently, when the girls demonstrated what they had learned upon real babies whose mothers, alumnae of the school, loaned them for the purpose. (Chicago News, 1-8-21.)

CALIFORNIA'S CHILD WELFARE RESEARCH

Appropriation of $50,000 for establishing a child welfare research station at the University of California is proposed in a bill before the legislature. The station would be under the supervision of the university regents, and the findings of its investigations would be made public through university bulletins and extension courses. (Tulare Advance, 2-10-21.)

DENTAL HELP FOR RURAL NEEDS

A traveling dental clinic in Pennsylvania for the benefit of school children of the rural communities is being planned by the state health authorities and the Pittsburgh Red Cross. (Pittsburgh Dispatch, 2-15-21.)

The Foreign Field

England

Infant Mortality Rates

A PROVISIONAL return for the birth, death and infant mortality rates for 1920 has just been issued by the Ministry of Health for England and Wales. The birth rate is the highest in a decade, while the general death rate and the infant mortality rate are the lowest ever recorded. The infant mortality rate for England and Wales was 80 per 1,000 births; for London, 75 per 1,000 births. (Manchester Guardian, 1-27-21.)

The infant mortality rate for the whole city of Manchester is 111.2;

that of one of the crowded sections, 191.6. The Manchester Guardian cites this as one of the evil effects of the housing shortage and states that no fewer than 150,000 people are living in "slum property". Over 20,000 houses are declared to be unfit for human habitation, but the health authorities hesitate to turn anyone out of them because they have no other houses to offer. In some cases whole families are living in a single room. The death rate in Manchester is abnormally high. (The Manchester Guardian, 1-27-21.)

India

Attempts to Improve the Maternity Service

THE valiant struggle of the Women's Medical Service of India against prejudice, dirt, and ignorance does not cease, and new methods are constantly being devised to popularize the health movement among Indian families. The annual report for 1919 of the National Association for Supplying Female Medical Aid to the Women of India records an increased government subsidy of 2¼ lakhs (over £20,000). It is also recorded that all hospitals under members of the Women's Medical Service now have qualified matrons and are engaged in the training of Indian and Anglo-Indian nurses and midwives. The Council note the revival of activity in the attempt to improve conditions of childbirth, and emphasize the need for the training followed by constant supervision, of the indigenous dai (hereditary midwife). The women of the poorer classes turn to the dai, even as in England, they used to cling to the handy woman, and experience has shown that more useful work can be done at present by educating the dai than by attempting to supplant her. The Victoria Memorial Scholarships Fund has decided to assist only indigenous dais to become trained midwives, since the few better educated women who desire training have other opportunities for obtaining assistance. Unfortunately the trained dai who works among those sections of the community tenacious of old customs tends to revert to former practices unless constantly supervised. An Association for the Provision of Health and Maternity Supervisors has been formed, but the difficulty of selecting candidates suitable to be trained for these higher posts is great. The standard of obstetrical knowledge required even of doctors, men and women, trained in India will also have to be raised if maternity conditions are to be improved. At present the universities require the candidate for a degree in midwifery to have conducted no more than six cases. On the other hand, Dr. D. Curjel, recently appointed medical secretary to the Victoria Memorial Scholarships Fund, records that interest and enthusiasm for child welfare schemes is becoming noticeable

throughout the country. A further indication of this interest is the success of the Maternity and Child Welfare Exhibition held at Delhi in February last. A sumptuous volume, excellently printed and illustrated, describes the various sections of this exhibition, and not only includes the leaflets and pamphlets issued, but reprints the lectures delivered. Among the medical lecturers were Dr. A. Lankester, Dr. Ruth Young, Lieutenant-Colonel A. Frost, R.A.M.C., Major F. Cragg, I.M.S., and Dr. Yamini Sen. The need for attention to child welfare in India could not be emphasized more strongly than in the results of two inquiries quoted by Doctor Lankester. The total number of pregnancies in a series of fifty married women who presented themselves at the Lady Dufferin Hospital at Karachi was 241. The number of children surviving was 20. In Delhi, of 1,000 consecutive multiparae attended in labour, 657 had lost their first-born.—(The Lancet, January 29, 1921.)

France

City Hospital for Unmarried Expectant Mothers

LYONS has opened a lying-in home with workrooms, to be run on liberal and humanitarian lines, for the unmarried mothers of the entire department in which Lyons is situated. While the primary purpose of the home is the prevention of abortion, it also affords to the baby a good chance of life, and to the mother an opportunity to work. It was opened in September, 1919, with forty beds; it now has thirty-four more beds.

A woman is expected to pay something towards her maintenance, if she is able to do so, but no inquiries are made on admission and no information is demanded. The only conditions are that the women shall nurse their babies at the breast, and do what work they have strength for, either carrying on their own profession or learning some easy and remunerative trade. The profits made are divided equally between the mother, the baby, and the home.

The following are some of the rules and regulations laid down in the home:

Each mother must undertake to nurse her child as long as the doctor thinks desirable, and must carry out his orders, particularly those concerning nourishment for herself and the baby.

No mother is allowed to have her baby sleep in bed with her.

Pacifiers are forbidden.

Babies must be left out-of-doors in their cradles for the greater part of the day.

Cleanliness for mother and child is strictly enforced.

No woman leaving the home has been known either to abandon her baby, or to fail to take up regular work, and so far there has been no death among the babies, who thrive

apace in their good surroundings. Such results seem to show that this work is valuable both on social and moral grounds.—[Abstract of Dr. Paul Vigne's article in Maternity and Child Welfare, 1920, iv, 2, 359-360.]

Birth and Death Rates

A comparison of the French birth-rate figures with those for the German district of Dusseldorf shows that the German birth-rate, even during the war, did not sink as low as the French. The rate in Dusseldorf now exceeds 20 births for every 1,000 inhabitants, while the French average is 7 to 8. Infantile mortality in Dusseldorf, which has decreased since the war, is now 10 per cent of the children born, while the French rate is in the neighborhood of 20 per cent. (Medical Officer [London], 1-8-21.)

A Congress of "Family Unions" was recently held in Lille, to consider the birth-rate problem in France. As a remedy to check the falling rate, the congress proposes an extra wage proportionate to the number of mouths the workman has to feed, and an increase of the universal suffrage by the institution of the family vote. It is thought that this campaign will cause many Frenchmen to see in the creation of large families not only a duty, but a personal advantage. Moreover, "As labour becomes more and more scarce, expensive and exacting, the small tradesman, artisan, employer and above all the small farmer, will not fail to perceive that children can profitably replace hired assistants. Once this truth is realized, the problem will be solved." (Jour. des Debate, 12-7-20, quoted in the Economic Review, 1-14-21.)

School Hygiene League

A League of School Hygiene has been organized in France, to call attention to conditions harmful to health in the present school regime, encourage out-of-door exercise, guard against mental over-exertion, and secure more active participation of physicians and fathers of families in the conduct of the schools. Local committees will be organized in each district to work for school hygiene. (Office de la Protection de l'Enfance, December, 1920.)

Germany

Domestic Science for Girls

A RURAL domestic science school for girl graduates of the public schools of large cities has been opened outside Berlin, by the Association of Berlin public school teachers. The purpose of the school is to strengthen the girls physically and morally by useful work, and to teach domestic science, gardening and the care of domestic animals. The course, which is for one year, is intended to prepare for higher agricultural and domestic science schools. (Zeitschrift fur Kinderschutz und Jugendfursorge, November, 1920.)

New Laws on Maternity and Child Welfare in Prussia

A DECREE on maternity and child welfare, recently issued by the Prussian minister of Social Welfare, calls attention to the new laws soon to be enacted establishing a child welfare system and regulating midwifery, and suggests some measures of reform which should be taken pending this legislation. He recommends the immediate establishment, in all municipalities and rural districts, of consultation centers for all expectant mothers, whether married or single, to be connected with welfare agencies already existing, and with an advisory committee, preferably of women. The minister considers that these centers should be under the direction of public officials. (Zentralblatt fur das Vormundschaftswesen, etc., 10-15-20.)

State Examination for Child Welfare Workers

State examinations for women welfare workers were established November 1, 1920, open to women 24 years old or over, who have completed a two years' course of study at schools of social service approved by the state. Examinations of three classes are given, in (1) public health; (2) child welfare; (3) general welfare work. After passing the examination, the candidate is placed on probation for one year before she can receive the state diploma. This diploma may be withdrawn if the recipient shows unfitness or disobeys government regulations. (Veroffentlichungen des Reichsgesundheitsamtes, January 5, 1921.)

Austria

Children's Holiday Homes

UNDER the title of Children's Holiday Homes in Austria, the Friend publishes an account of the work of "hospitalization" done by the Society of Friends last summer in collaboration with the city of Vienna and other Austrian organizations. At least 2,615 children were placed during the summer. Most of the "Homes" were situated in lower Austria, where the country is very beautiful and the air is healthful. The Society of Friends furnished thirty-eight "Homes" with flour, condensed milk, fats, and so forth, and paid the bills for fresh food such as milk, eggs and vegetables. Sixty-one tubercular children were sent to a beautiful home at Krems and sixty deaf children had a two months visit at Ybbs. A member of the Mission who went to visit them declared that he would never forget the joy that spread over the children's faces when they saw the playthings he was bringing. In two months, the average increase in weight of the children was 8.8 pounds. This fine result was due to the good food, to the fresh air, to the obligatory rest after meals, and to almost daily

baths. (Bulletin de l'Union Internationale de Secours Aux Enfants. December 20, 1920.)

An American Farm for Convalescent Children. A committee of Austro-Americans, presided over by Dr. Otto Glogau, at New York, has created recently, at Vienna, an establishment of convalescence for 200 children suffering from rickets and tuberculosis. This home is installed in an exemplary way and being provided with all modern conveniences, has given remarkable results. Unfortunately, as soon as the children return to their families, they very often lose the benefit of their stay at the sanitarium. As a result, the committee in New York, desirous of enlarging and of completing its activity, has created, in the suburbs of Vienna, a farm for children, similar to several already existing in the United States and has decided to spend $250,000 for this work. The only condition that they make is that land will be put at their disposition, without charge.

Besides the living buildings, the proposed farm will include a hospital, administration buildings and workshops, a gymnasium and all the installation necessary for agricultural work. An arrangement will be made so that the colony will be entirely independent of outside sources for its milk supply. The patients will receive a regular school course and will be occupied with suitable work in accordance with their physical ability.

This "Home", which is an entirely new kind in Europe, will be ready to receive 1,000 children who will be able to stay there until the end of their school age. (Bulletin de l'Union Internationale de Secours Aux Enfants, January 10, 1921.)

The Older Children in Vienna

Children of Vienna. A phase of relief need in Vienna which has received little attention is noted by Dr. Hilda Clark, Head of the Friends' Emergency and War Victims Relief Committee, Vienna. Doctor Clark says that smaller children in Vienna are now better off than a year ago, but the greatest burden of suffering rests on the frail adolescent children, between 14 and 20 years old. In 1919 there died of tuberculosis 1,021, as compared with an average of 480 before the war, when the population was larger. The whole cause is starvation. Boys and girls of adolescent age need very nourishing food and there is none for them. Rations have been shared with special care that the smaller children should not lack, and the older children have suffered more than they. American relief agencies are giving a daily meal to 12,000 apprentices, for most of whom this is the only meal for the day. But the children of the "brain-worker" class are harder to reach, unless they are in school, and these the English Friends are trying to reach by distributing rations.

The Friends' Organization has a

plan for opening new wards in the Vienna hospitals for tuberculous children. All the children with natural tendencies to tuberculosis died long ago, and these children, who naturally would be strong and robust can be cured if taken in time.

The Austrian government is trying to increase the milk supply by giving the farmers a supply of cattle feed in proportion to the amount of milk they sell to the city. (Manchester Guardian, 1-8-21.)

Poland

Schools Under Medical Supervision

MEDICAL supervision for all the schools of Poland has been established by a recent government regulation. Records must be kept showing the sanitary condition of the school premises and a list of the cases of contagious diseases among the children. Each school physician must give at least two hours daily to school work, and in the secondary schools dentists are appointed who are required to give at least two hours and a half a day to the school work. In Warsaw and Cracow dental and eye clinics give treatment to primary school children. In many of the cities school baths are provided.

Because of the shortage of physicians, there are now in Poland only 390 school doctors, of whom 92 are in Warsaw. (Oeuvre Nationale de l'Enfance, October, 1920.)

Care and Cash for the Employed Mother

Maternity benefits are provided under the compulsory sickness insurance law, enacted in May, 1920, for all employed persons irrespective of income. The benefit consists of medical care before, during and after confinement, a cash benefit for eight weeks equal to the amount of the wages, and a nursing benefit for at least twelve weeks more. Half of the expense of the system is borne by the state treasury. The law is already in force in the part of Poland formerly belonging to Prussia, and is to come in force within three years in the other sections. (Soziale Praxis, 12-1-20.)

Switzerland

Open Air Schools

OPEN air schools have been established in a number of cities and mountain and forest districts in Switzerland, most of them being for delicate children, though a few are for children of all classes. In one school, absences because of sickness were only one-fourth as frequent as before it was made an open air school, while in a neighboring school, conducted in the usual way, the proportion of such absences was unchanged. During the last election campaign in Geneva, almost all the political parties included in their platform the extension of the open air school system. (Paris Medical, 1-1-21.)

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HOUSING VS. HEALTH

The social aspects of housing are receiving considerable attention in journals and in measures before the various state legislatures. The effects of bad housing on the health of children are emphasized.

The Bulletin of the Extension Division, Indiana University, for January, 1921, is devoted to the High School Discussion League Announcement for 1921. The subject for the series of school debating contests for 1920-1921 is The Housing Problem. The Bulletin gives excerpts from several recent books on the subject, and a bibliography which includes a list of magazine articles.

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A Magazine Concerned With Their Health

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From an English Woman of 1850 to the Women of Today

THERE is something very wrong, for, so far from living to grow old, more than thirty babies out of every hundred born in this country die before they have lived five years. Those who should be in the cradle, lie in the churchyard; those who should be playing upon the daisies, sleep under them; on all sides "Rachel sits weeping for her children because they are not."

We have never been taught the laws of infant life and health and so we disobey them every hour, and thus cause the disease and death we mourn over. Yes, women have been in the world six thousand years and still, up to this very day we do not know how to manage our little ones. Then it is surely high time we began to learn.

[*Preface to a pamphlet on "How to Manage a Baby," published in* 1850.]

MOTHER AND CHILD

A Magazine Concerned With Their Health

VOL. II MAY, 1921 No. 5

The Value of the Summer Camp

Frederika Hodder

The Holton-Arms School, Washington, D. C.

SPECIALISTS in education today are offering a large variety of remedies for the alleged evils of the school system of the country. None of these remedies is perhaps so sound, so thoroughly in accord with the principles of modern education, as the summer camp for boys and girls. The movement is relatively new, but its development during the past few years has been so rapid that large numbers of boys and girls of this country spend part of their summer in camp.

During recent years thinking people have become convinced that three months of enforced idleness each year hinder the development of the child. Not only is the summer vacation of no value in building up body and mind, but it is hurtful to the character of the average boy and girl. It gives encouragement to listlessness and idle-

ness. Parents and educators have attempted various solutions of this problem. The tireless school-man has proposed school the year round. But most of us have felt that it is not so much school instruction that is needed during the summer months as attention to the physical development of the child.

It is generally acknowledged that education must aim to develop a strong physique. Yet, though we recognize the principle as sound, most of us are old-fashioned enough to believe that the child's health will take care of itself. Such is not the case. More and more, people are coming to recognize the need of giving especial attention to child-hygiene. The mushroom growth of summer-camps bears witnes to the fact that they are filling a real need in the child-life of America.

The first point to be considered in appraising them is the kind of life that the boys and girls live in camp. It is a return to the simple life. Camp-sites are for the most part chosen with a view to hygienic conditions. The greater number of camps are located near lakes, but on rising ground where conditions are favorable to good sanitation. The children are out of doors the whole day. They live in tents in most camps, and in many instances the walls of these tents are rolled up, so that the children are really sleeping out of doors. This tenting is, however, under exceptionally favorable conditions. The tents are provided with wooden floors, which are built two or three feet above the ground, so that they will be dry even in rainy weather; and the canvas of the tents is waterproof.

Every activity of the day is designed to contribute to the development of the boy or girl. From the setting-up drill in the morning until the last bugle in the evening, the life affords wholesome activities. The morning dip is invigorating, and the various sports, paddling,

A Typical Day In Camp

MORNING		AFTERNOON	
7.00	First bugle; all up	1.00	Dinner
7.10	Setting-up drill. Dip in the lake—optional	2.00	Rest
8.00	Breakfast	3.00	Tennis, canoeing, rowing, hiking, horseback riding, baseball, basket-ball
8.30	Announcement of plans for the day. Short talk on current events	5.30	Supper
9.15	Tent inspection	6.00	Games, reading aloud, story-telling around the fire, music.
9.30	Craft work; basketry, weaving, jewelry-making, designing, sketching, leather work, dancing, horseback riding	8.30	Crackers and milk
11.30	Swimming	8.45	Tattoo
		9.15	Taps

Reprinted from the booklet of Camp Holton, a camp for girls in Maine.

base-ball, and basket-ball develop the health and strength of the child.

The physical examinations that are given in most camps are of inestimable importance. In the ordinary course of school life, a child is given a physical examination each fall. The report is sent home to the parents. Perhaps this report is acted upon, but more often it is not. There is the unwillingness of parent and of the child to be overcome. There is no such inertia to be contended with under the conditions that exist in camp. The physical examination sometimes shows certain weaknesses. If these are serious, the boy or girl is not kept in camp, but if the defects are remediable—if perhaps the stethometer shows that the child is narrow-chested—that defect is in the ordinary course of camp life corrected by daily exercises for developing greater chest expansion. The camp nurse is more interested in keeping the young campers strong and healthy than in curing them when they are sick. Almost without exception, the physical examination at the end of the season shows a gain in weight, in strength, and in general health over the report at the beginning of the season. The gain is the direct result of living a simple life out of doors, of drinking pure water and the best of milk, of eating wholesome food three times a day and of not eating between meals. In a matter so simple as diet, the advantages are patent. The majority of children do not eat fresh vegetables, not so much because they do not like them as because they have never acquired the habit of eating them. But in camp the meals are planned with the single end in view that the child may have simple food, well-cooked, at the same time palatable and nourishing. No meal is served that does not include such vege-

tables as spinach, celery, and lettuce. The result is that children become accustomed to eating fresh vegetables. Meat is served once a day, and there are always eggs, milk, and fresh fruit in abundance.

In camp girls dress in middies and bloomers. The mere ease of movement and lack of restraint are healthful. There is plenty of rest for the growing boy or girl, for in most camps the children sleep ten hours. In addition to this, there is an afternoon rest hour, a time set aside, not for enforced inactivity, but for the relaxation that the boys and girls themselves want in order that they may enjoy afterwards the exhilaration that comes to a rested boy or girl through physical exercise.

The living conditions—the physical side of the camp life—are important in the development of the child; but important though they are, they do not in themselves furnish that which is most vital in camp life. The summer camp should be essentially educational. It is desirable that our boys and girls spend their summers where their physical well-being shall receive especial attention. But we want more than that. The camp has a very real part to play in educating the child. In an age so complex as this, we must not overlook the importance of time in the life of a child. Each month must give him the largest possible return. It is not enough that he sleep well and eat well and be happy; the time should be utilized in such a way as to contribute directly to his education.

And by education I mean not mere book learning. The experimentalists are at present holding the stage of the educational world. They tell us of project-teaching. When in camp girls and boys live the things that in winter teachers contrive only with the greatest ingenuity to introduce into the class-room, then project-teaching takes on real educational value. How much better to teach children the proper movement of the toothbrush night and morning, when they naturally brush their teeth, than to interrupt their class-room work in the winter months to teach the art of brushing teeth! How much better that they learn the essentials of hygiene by putting into practice the principles that are commonly taught in sixth-grade hygiene books! They can be instructed in the proper way to bathe, and their attention can be called to the effect of hot and cold water upon the pores of the skin.

In many camps there are formal classes; there are Red Cross and first-aid courses. These are perhaps more successful in camp than under different conditions, because the boys and girls can see clearly the necessity of knowing what to do in an emergency. There are bruises to be bandaged and cuts to be disinfected. The fact that knowledge of hygiene is an every-day need stimulates an interest in first-aid remedies that makes the boys and girls apt pupils; and they

learn far more readily in this altogether natural way than they ever learn through the more formal instruction of the schoolroom.

Within school walls educators strive after the so-called socialized recitation in the hope that it may be the means of arousing each pupil to contribute something to the work of the group. In camp, where boys and girls are applying themselves to working out some particular problem in first-aid, the socialized recitation becomes not something to be labored for, but most natural expression of the eager interest of the group.

What is true of Red Cross work is equally true in classes where the girls learn the elementary principles of nutrition and dietetics, and the boys do wood-carving and other kinds of manual work. There are perhaps no other conditions so favorable to learning handcraft of all kinds. It seems to go with the life that the boys and girls lead in camp. It is infinitely better that such skill be acquired in this way, with little effort, than that time be taken from the other subjects of our already over-crowded school curriculum to give increased time to manual training. Such a program enables us to train well-balanced boys and girls.

In still other classes, the work is correlated with winter schoolwork. Nature study walks make the children familiar with birds and flowers and trees. What other way so natural as this, for interesting children in nature? Nature study walks cultivate powers of observation and give an increased knowledge of the notes of birds, and of the secrets of the woods, that is in itself valuable.

Perhaps the dramatics, pageantry and oral reading that are possible in camp are of even greater educational importance. It is hard to overestimate the value of this work in enriching the knowledge that boys and girls have of literature and of history. The camp offers a natural opportunity for the dramatic reading and pageantry that the pressure of more imperative training crowds out of our school courses. Dramatics and reading aloud vitalize and enrich the knowledge that the children acquire in school. The story of Betsy Ross has so little historical foundation that our sober school histories can scarcely touch upon it. Yet few people would deny that a Fourth of July tableau showing the origin of the American flag can help to make Revolutionary times real to the child mind. It is through such scenes that children learn of Barbara Frietchie, and Nathan Hale, and the other picturesque characters of our history. Though these stories have no place in the history of scholars, do they not arouse in children a zest and enthusiasm for history that are worth while?

But when we speak of the educational value of camp life, we have in mind primarily something even less formal than nature study walks and dramatics. The very life of the camp is educational. Long canoe trips give countless opportunities for enriching the experience of children. The building of a fire, the cooking of meals in the open, the making of a spruce bed —all these are things that in themselves are worth learning to do. A knowledge of swimming, of diving, and of life-saving, and the skill acquired through practice are valuable to children. It is worth while for boys or girls to devise a shelf in their tents for tooth-paste and the few toilet articles that they take to camp. It is worth while for boys and girls to get away from the environment in which others do things for them to a life in which they are helped to do things for themselves.

Boys' camps and girls' camps are very much alike. Perhaps boys' camps are somewhat simpler, for many girls' camps have hot water and other conveniences that boys scorn. The boys pride themselves on their Spartan spirit and are even more self-reliant than the girls. The girls' tents are more comfortable; their life is camping *de luxe*. Very naturally the training of boys and girls differs somewhat; whereas the girls have especially equipped kitchens for cooking and the study of dietetics, and have class work in jewelry-making, weaving, sewing,

and bandage-rolling, the boys have shops in which they do wood-carving and carpentering. But the sports in the two camps are similar —paddling, base-ball, basket-ball, riding, archery, and javelin-throwing.

Let us ask ourselves seriously what is the greatest good that we can hope may come to our children from camp life. It is the spirit of cooperation. The camp is for two months a community in itself. Each member contributes what he can to the happiness of the camp. In their games, in their tent-life, in their close friendship and comradeship, the campers learn to work together, to forget to be critical of others; they learn to be kindly and thoughtful. They learn that the welfare of the group is more important than their own particular desires; and they learn that real democracy means that the will of the majority shall prevail. Through consideration for others and through unselfish and tireless loyalty to the interests of others, in their work and in their play, they learn to adapt themselves to their environment, to be better members of society.

Possibilities of the Summer Camp in Health Education

John Foote, M. D.

THE summer camp for the youth of both sexes and even for children of a minimum age of five years has become extremely popular within the past few years. The idea of placing the city-reared child or youth in well guarded and supervised outdoor surroundings, during the summer months, where he may have in properly planned outdoor sport an opportunity for an expenditure of that excess energy which is a natural characteristic of every healthy youngster—this idea has had a wide appeal recently as shown in the increase of the number and the overflowing attendance at these camps. The Boy Scout movement may have had something to do with popularizing the summer camp; in any event it is here to stay and must be considered as a potential influence in the health of the children of school age.

NECESSARY HEALTH STANDARDS

What should be the health standards of the summer camp? How is a parent to appraise the value of one particular camp as against another when judged by the standards of (1) health protection of residents, (2) medical attendance and supervision and (3) continuation of lessons in personal hygiene which are given in most public and

a few private schools? Certainly he will not receive any help from the ordinary advertisements of summer camps which appear in periodicals and magazines. The writer undertook recently to read in three different magazines the advertisements of some forty-four summer camps, some for boys and some for girls. One advertisement alone of a girls' camp mentioned that a trained nurse was in attendance. Among the boys' camps, the only reference to health care was found in one solitary advertisement which said briefly "resident physician", at the very end of the catalogue of "attractions". And yet, no point is the subject of more apprehension by parents than the health of children during their residence in the summer camp. Strangely enough a fear of illness and an indifference to measures aimed at its prevention is not an unusual parental attitude.

Let it not be understood that by health care is meant general care in the sense of ordinary sanitary engineering problems — water-supply, drainage, and so forth, or foor problems such as clean milk, and so forth. It is very unlikely that any camp would violate these elementary requisites to the health of persons living a community life. Besides, there exist State Boards of Health to see that minimum standards concerning these utilities are enforced. But it is not anybody's business to see that other standards of health, almost as important, are enforced in many of these summer camps—unless indeed some supervisor or teacher with more than ordinary vision, undertakes on his or her own initiative this work of health salvation and education.

It is all very well to say that fresh air and sunshine may cover a multitude of hygienic sins—they should not be allowed to do this; on the contrary, the summer camp should be an outdoor school for continuing and applying the positive lessons in personal hygiene begun in the scholastic institutions of the city.

PERTINENT QUESTIONS

How many summer camps really do constructive health teaching? How many really have competent public-health nurses, or medical experts in school-hygiene as a part of their necessary equipment? "Children shouldn't be bothered with such things when they are living a natural life"—this is an obvious, and a frequent, excuse for the lack of health supervision. But it is not a good excuse. An inspection of the mouth and teeth once in two weeks is quite as important as setting-up exercises or swimming lessons every morning. And it is easy for a boy or girl to become careless about dental conditions in the rough and ready life of the woods. Of course the tooth-brush drill is much less exciting than the swimming contest—but that is all the more reason why it should be done for its own sake, as well as an important reason why it is frequently neglected.

The term "trained nurse" is far

from being standardized sufficiently to mean anything very definite. "Registered nurse" stands for a conformance with certain theoretical standards in nursing; but for questions of public health, the public-health nurse should be employed—for the term "public health nurse" has come to mean one competent to teach practical personal hygiene. The summer camp is a community involving public health problems, both practical and theoretical. Not only a resident or a daily visiting physician, but a public health nurse, should be part of the executive personnel of every summer camp.

HEART STRAIN AND EXAMINATIONS

Most summer camps require each prospective member to submit a standard form filled out by a physician and testifying to the physical soundness of the candidate. This includes a questionnaire as well as a blank on which is to be recorded the results of a physical examination. Particular stress is laid on the tests for the functional capacity of the heart—the sounds and pulse rate before and after exercise usually being recorded. This, of course, is right, and proper. The method employed is perhaps as good as any other such routine procedure. Yet anyone familiar with the work of Dr. Charles Hendee Smith knows that it is frequently almost impossible for even an expert to accurately determine the functional capacity of the child's or youth's heart, by any method however complicated or simple. This heart examination, done often by the family physician, is therefore not sufficient for the purpose for which it was intended—that is, to make certain that unusual muscular strain will not be placed on the circulation in the strenuous exercises of the camp. Not that this examination will not bring to light many damaged hearts. It will; but nothing short of repeated and frequent examinations made at the camp itself will adequately reveal the actual reaction of the slightly impaired heart to the strain of the daily exercises of the camp program. A physician, and a competent physician, on the grounds or within hailing distance, is an actual necessity if strain is to be avoided in the slightly damaged hearts.

The proximity of the nearest hospital for the treatment of acute surgical conditions such as appendicitis, deep wounds or fractures is, or should be, an important feature to be considered in choosing the location of a summer camp—this and means of transportation for the sick to and from such a hospital.

A POSSIBLE IDEAL

The actual teaching of health in a camp is an ideal—but only an ideal. Red Cross classes, bandage-rolling, first-aid—these are often found in girls' camps—but health lessons, lessons in the preservation of health, are absent, or so rare as not to be heard of. And yet, it would be simple enough to explain *why* fresh air and sunshine are

healthful; *why* chilling and fatigue may favor infection; *why* bathing aids elimination; *why* simple food is good and candy and coffee bad for the health; *why* exercise is healthful and *what* good teeth mean aside from their cosmetic utility. These and many other questions could be made clear by a series of health talks, that would have practical application to the daily life of the camp, and be remembered long afterward. Such lessons are frequently taught in our public schools; very seldom in private schools. Indeed, the health program of the average private school is scandalously inadequate—being as it frequently is, simply a more or less effective attempt to quarantine such students as have contagious diseases. It is a negative program; there is no constructive teaching of methods to be used in keeping well.

HYGIENIC INDIFFERENCE

More than two-thirds of the summer camps advertised in magazines are under the direction of principals or managers of private schools. The indifferent point of view of some private schools toward constructive hygienic measures has been well demonstrated; but it is only fair to state that the point of view of the average parent is not only no better, but actually worse. If the parent *demanded* the teaching and enforcement of hygienic methods in the private school, some sort of effort would be made to comply with his demand. Truly, as Mr. Herbert Hoover said, "parents need much bringing up", and until they are educated to the necessity of having their children taught to live hygienically, whether in school or camp, few schools or camps will be any better from the health standpoint than they are today.

Every parent who intends to place a son or daughter in a summer camp, far away from home care and influence, owes it to himself as well as to his children to ask in writing, *"What health protection and what health teaching will the camp give my child?"* The results of such an inquiry would be surprising and possibly even disconcerting, if analyzed by an expert in health matters. Every dweller in a large city has an invisible, though no less effective, army of health experts continually at work to protect him against disease and teach him cooperation in health protection. It is too much for promoters of the summer camp in the country or the forest to expect Providence to take over this entire work, without at least a reasonable amount of encouragement and assistance on the port of the camp authorities.

Courtesy of Perry Walton.

Child Hygiene in a Visiting Nurse Association

Mary Beard, R. N.

Director, Instructive District Nursing Association, Boston.

THE period just past has been one of intense specialized development in public health nursing. In 1902 school nursing was established for the first time in this country. In 1905 the anti-tuberculosis movement began to find its expression in the work of visiting nurses, known as anti-tuberculosis nurses. In 1910 as a result of the efforts of the American Association for the Study and Prevention of Infant Mortality came the development of the so-called well-baby nurse.

During these years pioneers in pre-natal nursing had discovered the great value of visiting nurses,

but it is only within the past five years that anything like a general development of pre-natal nursing care has been under way.

Such a period of intense specialization has been essential to a recognition of the health needs of those families which compose our population. However, the emphasis of the present has become and must continue to be quite different from that of the past. The nursing movement is following the lines taken now by all the other great national public health movements. The campaign against tuberculosis finds a new emphasis as a result of scientific studies which have recently been made.

Dr. Allen K. Krause, in an article published in the Journal of the Outdoor Life, January, 1920, makes the following statement:

> "First, infection is almost universal, yet morbidity is relatively very low; second, a long interval elapses between infection and the manifestations of disease that may result from the infection, and third, the manifestations of disease are not uncommonly ushered in or precipitated by collateral events in the life of the individual.
>
> "In other terms, something besides mere infection is necessary to the clinical expression of infection. Morbid infection depends not so much upon infection as such as upon non-specific contributory factors. Inasmuch as almost all of us still go about our daily business infected yet healthy people, and because it is tuberculosis morbidity that is really responsible for all the evils of tuberculosis—if in every case infection could be confined it would give us little or no concern—perhaps our most important practical task is for the time being at least, to accept infection as part and parcel of the normal make-up of man, and to lay the emphasis on preventing morbidity. In my opinion, so long as the present situation exists, this is the heart of any conceivable progressive program; and I should like to discuss this phase at some length.
>
> "Tuberculosis—public health—for their programs are identical—must achieve a publicity such as heretofore has probably never been dreamed of. Our organizations must be enlarged ten and a hundred fold, and in every hamlet the preacher of public health must be as familiar and active a figure as the school teacher, or the friar in the lanes of old Quebec."

POSITIVE HEALTH BUILDING

Our effort must now be centered upon the *positive* health of all the members of all the families in all neighborhoods. We must somehow secure the interest of fathers and mothers, aunts and grandmothers, boys and girls, in the prevention of disease and the correction of defects. In short, in that genuine and general attitude toward physical perfection which the ancient Greeks so well understood, and which we Americans have so sadly failed to recognize.

If effort is directed toward such an ideal, we shall center our interest upon the family and the unit of population as a basis for that concentration of effort, that elimination of minor interests, that constructive building up, which alone can produce results in the period upon which we are now entering.

PROTECTION OF MOTHERHOOD AND INFANCY

Ten years ago the agencies established in the attempt to reduce infant mortality were known as milk station committees, as milk and baby hygiene associations, or some similar name and dealt very largely with the problem of providing a pure milk supply. It was found necessary to employ visiting nurses (or nurses of a similar name) even at that early stage in the work for the reduction of infant mortality. This initial stage in the campaign for the reduction of infant mortality has been passed successfully in one city after another. The effort to produce a pure milk supply has been more or less successful. More and more has our attention become focussed upon the really important feature in the whole campaign which is, of course, the family of the baby. How to demonstrate to mothers the care of young babies; how to help them to secure conditions which will produce a proper standard of living, has become the heart of the child hygiene movement. The protection of motherhood and infancy, a phrase coined by Miss Julia Lathrop, has in the past four years come to express the purpose of child hygiene work. For the protection of motherhood and infancy we have learned that five things are required:

1. Regular and systematic instruction of the mother during pregnancy.
2. Proper care of the mother at the time of confinement.
3. Proper care during the ten days or two weeks while she is in bed.
4. Supervision and instruction of the mother during the baby's first two years of life, by means of well baby clinics and nurses to visit the homes to demonstrate and teach.
5. Supervision of the child between two and five years of age, when he will begin to go to school.

The nurses of the Instructive District Nursing Association in Boston are in intimate touch with four thousand families daily. The number is large because the service of nursing the sick opens many doors to them. The number of private doctors with whom the nurses work is six hundred. The sum received from patients in 1920 was $28,478.-04. The sum received through Metropolitan Life Insurance Company payments was $34,121.35. These fees are mentioned because the policy of accepting payment for nursing service insures a large proportion of independent families of moderate means. These families are not often reached by purely preventive non-payment agencies. A sliding fee scale provides the opportunity for giving free service. The very large number of mothers and babies coming under the observation of visiting nurses, who give bedside care, makes a strong plea for the utmost use of their unusual opportunities that they may also give that specialized teaching service, performed in the past almost exclusively by Child Hygiene Associations. There is a point in the progress of the five necessary services to mother and baby where

bedside nursing must come in (See 2 and 3 above) and there will come other breaks also when well children become sick children. Just as Dr. Krause, in his article referred to above, shifts the emphasis in present day tuberculosis work from the sick person to his family before he becomes a sick person—emphasizing family health work as the foundation for the fight against pulmonary tuberculosis *because we must admit infection as almost universally present* and must therefore struggle to maintain health conditions so that the process will never become active, so in child hygiene work we must admit that successful public health nursing for the protection of motherhood and infancy must include a well rounded health program for almost every family in a neighborhood. From such a plan the care of sickness can not be excluded and is undeniably a very great asset because it so greatly extends the field of service, making it possible for nurses to teach health in many homes not open to them otherwise.

ORGANIZATION FUNDAMENTALS

Therefore, we are brought to the conclusion that the best and most practical method of securing family health is also the only practical method of reducing infant mortality. To build up an organization capable of securing family health in a neighborhood, one needs certain fundamental elements. There must be:

1. Regard for a proper connection with health authority, represented by the Department of Health of the State, City, County, or Town.
2. A local committee representative of the various interests of the community. This committee should be capable of developing policies and giving widespread publicity to the needs of the community and also to the plan of health work which will be adopted.
3. A group of professional persons capable of:
   a. Conducting the various health clinics necessary, and of
   b. Doing modern public health nursing, which is family teaching.

Public Health organizations which cover these three essential points are usually developed more or less completely from the old district or visiting nurse association. Correlated with them, usually under separate management, one finds Baby Hygiene Associations. More and more frequently within Municipal or State Departments of Health, divisions of child hygiene are being developed. To whatever degree the child hygiene division or association is meeting its specific specialized piece of work, it will be found that the visiting nurse association is doing a great deal of the work which reduces the morbidity and mortality of motherhood and infancy.

The relation of the work being done by Visiting Nurse Associations to that which the specialist child hygiene associations are engaged in is an important question with public health administrators.

In Boston we are all thinking very seriously about the better correlation of present activities for the reduction of infant mortality.

In 1920 maternal mortality in the City of Boston was 7.6 per 1,000 mothers. Among the 6,066 maternity patients to whom the Instructive District Nursing Association gave either pre-natal or post-partum care, maternal mortality was 2.1 per 1,000. In the City of Boston in this same year infant mortality under two weeks of age was 37.34 per 1,000 births. In the District Nursing Association, where the nurses gave pre-natal care to 4,036 patients, it was 13.27 per 1,000.

A bill for providing maternity benefits in the State of Massachusetts is under consideration this year in the State legislature. This bill provides payment for nursing care,—pre-natal, natal, and post-natal—and will be available to any mother who has lived six months in Massachusetts, and who applies to the State Department of Health.

In two sections of Boston—Hyde Park, with a population somewhat over 23,000 persons, and Brighton, with a population over 36,000—the District Nursing Association maintains three baby health clinics—two in Brighton and one in Hyde Park. The Baby Hygiene Association of Boston provides twenty well baby clinics in other sections of Boston, to which the District nurses refer the babies whose mothers have been cared for through the pre-natal and post-partum period. In Brighton and Hyde Park, Health Centers have been established with the purpose of demonstrating that public health nurses can staisfactorily undertake the care of well babies, without the introduction into the family of a special baby nurse.

In 1920 the District Nursing Association cared for a total of 19,266 children and little babies. Of these, 2,624 were babies at three Baby Health Clinics. The sick babies and children cared for numbered 11,383, of which 1,492 were babies under 1 year; 2,123 children from 1 to 2 years; 3,322 children from 2 to 5 years; 3,007 children from 5 to 9 years; 1,439 children from 9 to 15 years of age. There were 5,136 new-born babies cared for. After care was given to 123 children with poliomyelitis.

Four hundred and twenty-five of the babies whose mothers were given post-partum care have appeared elsewhere in this tabulation, which brings the total to 18,841.

After care of infantile paralysis is carried on in the District Nursing Association through the special supervision of four staff nurses who

Courtesy of Perry Walton.

The District Nurse Helping the Paralyzed Child.

have taken Dr. Lovett's special course in muscle training.

Ninety-eight children are still under care from the previous epidemic. Most of these children are in good condition and are going to school, although many of them walk with the aid of braces.

One hundred and fifty-one children constitute the new list from the summer of 1920. Not all of these are ready for treatment yet. Probably about two-thirds of them will be treated eventually.

COORDINATING ACTIVITIES

We must think clearly how the care of the visiting nurse given under a maternity benefit act and including instruction of the mothers before the baby is born, bedside nursing at the time of birth and for the ten days immediately following, may best relate itself to the specialized nurse service offered by a Baby Hygiene Association, which conducts clinics for well babies, and to that of a District Nursing Association whose function it is to do health teaching and to give and teach bedside care.

The Boston Instructive District Nursing Association in its so-called health center in Hyde Park offers the following public health nursing service. Each nurse is given a small section of the town. The health of the families in that section is her responsibility. Any practicing doctor in Hyde Park may have the services of district nurses for pre-natal care, for care at the time of confinment and for the nursing care of the mother and baby during the first two weeks of the baby's life. After that time the nurses try to educate the mother to register her baby at the Baby's Health Clinic, which is held every week at the Health Center.

From the time the baby clinic was opened the milk supply of the town has been watched by the nurses. Every week a sample of milk from each dairy is sent to the City Laboratory for examination and the report of the bacterial count is recorded. The bacterial count is posted in the clinic room and the mothers are encouraged to read the findings and so to become intelligent judges of the best milk producers. The nurses collect the milk from the dealers, pack it in ice and members of the committee hold themselves responsible for taking it to the City Hall. It requires careful planning to insure this service uninterruptedly, but both nurses and committee members feel it is justified. It enables the nurses to know which milk supply is safest. On occasions when a baby has developed summer diarrhea the examination of the milk showed a high bacteria count. When the facts were presented to the office of the dairy company they sent their best grade of baby milk to the family at the price of the ordinary milk.

COMMUNITY SPIRIT

The attitude of the community is expressed by the business men whose offices are in the building. If Thursday dawns stormy they are quick to note it and are very helpful in getting the baby carriages

under cover and in helping a mother with more than one child up the stairs.

There is always in attendance a doctor who is a pediatric specialist. He is paid a moderate fee for his services. One of the committee members has assumed the responsibility of attending each clinic. She is not only a great help to the nurses, during this busy time, but gives an atmosphere of hospitality which the mothers are quick to appreciate.

When a baby "graduates" from the Baby Clinic, the nurses have been in the habit of visiting his home once a month while he is little. At the time of writing this paper, a second clinic is being opened at the health center. It is to be a children's health clinic and will be held on the same afternoon as that for the little babies. The pediatrician in charge will have one or two assistants, but he himself will be responsible for both clinics. The children received in the children's health clinics will range from two to fourteen years old. A feature of this clinic is to be the development of nutrition work of a practical kind.

DENTAL PROPHYLAXIS

In connection with health work for children from the Hyde Park Health Center we felt the need of more facilities for dental care, for while the school nurses examined the teeth of the children in the public schools, above the second grade, the younger children and those in the Parochial Schools were not examined. The nearest clinics necessitated a long ride, changes of cars, and two carfares. In March, 1918, a dental clinic was opened in the station, a graduate dentist procured for three days each week, and two full time dental hygienists.

The service was given to demonstrate that decay was already established before the children reached the third grade and that dental care should begin early, in order to save the six year molars, and that it should be available to everyone. Each hygienist had a portable equipment and each public school was visited in turn. The teeth of all first and second grade children were examined and defects charted and a prophylatic treatment given. Tooth brush drills were given to groups. Ninety-five per cent of the children were found to have defects and these were referred to a private dentist or to the dental clinic in the station. These children were followed until they had received the necessary care. Homes were visited when necessary, and parents told of the importance of dental care. Tooth brush drills were given in the parochial schools and all children were allowed to buy tooth brushes at cost price.

The results of this demonstration were presented to the Board of Education and while the members were convinced of the importance of the work, school funds were not available to extend it to the other schools. The work of this demonstration was interrupted dur-

ing the 1918 epidemic of influenza, but was resumed as soon as advisable and was concluded in March, 1919.

In August of the same year the clinic was resumed on a different basis. It was made available to any member of a family whose income did not exceed $4.00 per week per capita. No gold fillings, nor plates were attempted and no work under anaesthesia. The charges were very moderate, representing more than the cost price of the material, but not covering the amount paid the dentist. There was a little newspaper publicity for this, but most of the patronage was and still is secured through the personal work of the nurses in the homes. There was splendid response from the first, parents welcoming the chance to get their children's dental work done at a price within their means and without paying two carfares. The nurses soon felt that the per capita rate was keeping out some families whose income did not permit a private dentist and the Board of Directors raised it to $6.00. The dentist is busy two days a week and there are always appointments several weeks ahead. The clinic plays an important part in the every day routine of the nurses.

OBSTETRICAL NURSING SERVICE

The health activities of Hyde Park have developed as rapidly as funds were available. The latest developments, made possible by a gift from the American Red Cross, are the maternity and hourly nursing services. These were started July 1, 1920, by the addition of two nurses to the staff. They live in the district and are available for maternity service day or night. The doctors have welcomed this service, but the best response has come from the patients themselves. The fee of $5.00 gives the patient the services of the nurse to assist the doctor at time of delivery. Subsequent nursing care is given by the regular district nursing service. As in our other services, there is a sliding scale of fees; free service being given when it is necessary.

INTERLOCKING PROBLEMS

The daily planning of the work requires eternal vigilance and quick readjustments. With one group of nurses handling so many activities it is easy to over emphasize one at the expense of another. When Tommy Brown has pneumonia, it is not difficult to get so interested in him that the preventive and instructive work lapses a little.

When the Hyde Park Health Center was opened and pre-natal nursing was begun many of the doctors were unwilling to have the nurses do the routine urinalysis which is the custom in our pre-natal care. As time has gone on, however, they have become much interested in the result of this care and appreciative of its benefits. Seven of them have now requested us to make a urinalysis on visits to their patients.

One can not profitably or intelligently separate the problems of

sickness from the problems of teaching health in homes, for it is the family which must be our unit in all community work. The prenatal patient who for months needs teaching on the hygiene of pregnancy becomes presently a patient needing nursing care involving a knowledge of asepsis and obstetrical technique, and later a convalescent needing bedside nursing and then, for many months, a well person needing regular supervision and instruction in the care of her baby. Social adjustments must be made in many instances and food values taught in many families. Physical defects must be corrected and occasional acute illness cared for in every family.

The reduction of infant mortality, and lessening of sickness among children must concern itself with so many sides of the child's environment and with so many age periods that it has become, like the problem of tuberculosis, a matter of the right kind of neighborhood organization for family health teaching. The form of organization which will be most successful in raising the family standard of health is the one which will be most successful with the special problems concerning motherhood and infancy.

Economic and social factors play an important part in the well being of the baby from early weeks of life throughout his childhood, but ignorance of the simplest rules of the hygiene of pregnancy, regardless of income, appears to govern the maternal and infant mortality rate (under two weeks of infant life) and this period has received less attention than the other.

We are looking with great interest to the National Child Health Council to show us how to coordinate our services for children's health. To carry out various plans for the family to their logical conclusion would produce such an army of workers in every neighborhood that all of us would agree that coordination was the only salvation.

A Plea for the Country Child

Agnes Van Auken

THERE is a traditional idea prevalent among townspeople, or perhaps more truly, city people, that the country child is by force of circumstance, a healthy child. A countrywoman by marriage only, I can remember vague pictures floating before my mind's eye—pictures of fat and rosy-cheeked children, playing in the pure, fresh, undefiled country air. I have found to my sorrow, that these pictures are but figments of the imagination and have little, or no, foundation in fact. I understand that cold statistics point to the truth that the

mortality among country children is greater than that among children of the city.

I have met with an ignorance and superstition, concerning the care of mothers and babies, which seems incredible in this day. Many of these people have heard indirectly of some of the more modern methods of bringing up babies, and speak with the utmost scorn of such newfangled notions. To these people, it is incredible that a doctor, a mere man, and especially a young doctor, can possibly know more about bearing and raising children than their mothers knew—mothers who had had six, or eight, or ten children.

A DISCOURAGING DUTY

It is discouraging work for the doctors. One of these, who has a large practice in the country, told me that his greatest trouble is with the grandmothers. He told me of one instance, which he affirmed was typical. He was called to attend a birth and successfully delivered a splendid, eight pound boy. The mother had plenty of milk and all seemed well. The physician gave very strict instructions that nothing was to be fed the baby except the breast milk. A month later he was sent for and arrived at the farm to find the baby skin and bones. Of course he immediately asked what they had been feeding the baby. Grandmother and mother were both present, and the latter asserted that his instructions had been followed to the letter. "Very well then," said the doctor, "something must be wrong with your milk, it so evidently disagrees with baby. Come to my office Saturday when you are in town, and I'll examine your milk." The woman appeared at the appointed time and began by announcing that she had a confession to make. "I didn't want to tell you before her," she said, "but Mother has been feeding baby mush and milk."

At another time, a woman brought her baby to the doctor to be weighed. The child was far below normal, and the doctor found that the child's diet consisted of a mixture of flour, water and milk, administered whenever he showed supposed signs of hunger. The mother was given a formula, and asked to bring the baby back in a week's time. When the week was up, the doctor weighed this baby again, to find there had been absolutely no gain. He asked the mother if she had been following his formula and she said, "Oh, no, I've been feeding him just the same as I was before. Mother raised all of us on that and there are eight of us—all strong, healthy men and women." The doctor, telling of the incident, admitted that for a moment her argument seemed unanswerable. Then he said, "Did your mother never lose a child?" "Oh, yes, four died when they were babies."

THE PICKLE-OLIVE-BANANA DIET

I know one young farm woman, whose baby was born at her mother's home. She told me she got

up on the third day after the baby was born and helped with the housework. On the ninth day, however, her mother insisted she lie flat on her back all day, so that "everything would go back in place." After that she was considered ready for anything. This same young woman had an older child, a pretty, but anaemic looking little girl. The mother told me she had given this child pickles, olives and bananas to eat when she was six months old. "She just loved them, so I thought they must be all right for her." And a few minutes later, this mother was wishing she had a dollar for every bottle of medicine whose contents had gone the way of the pickles and olives, but she had no thought of any connecting link between these two statements.

I tried to instill into this mother's mind some of the valuable information I had acquired on the subject of the care and feeding of my own small family. But my success was negligible. She did not see in the concrete and robust example of my own small daughter, the product of regular hours and regulated diet. I longed to point out the difference of results we had each achieved by our respective methods, but I refrained.

ACCIDENTAL HEALTH

People of this sort regard health or ill health as purely accidents of nature. The former is taken as a matter of course, and the child who continues to thrive, in spite of the tremendous odds, is more or less disregarded, and allowed to go his own way unmolested. The unhealthy child, on the other hand, is not only the object of every kind of home remedy, but is also the subject of long, detailed conversations, for there is nothing so interesting as illness to the minds of the ignorant and uneducated. A doctor is not called until all else has failed. Usually by that time it is too late, and the reputation of that doctor in particular and of doctors in general, suffers accordingly. Doctors are considered necessary only in the most extreme cases, and even then the opinion of some old woman is very apt to be listened to with more respect.

OVERWORKED MOTHERS

The home demonstration agent of a nearby county working in connection with the farm bureau, and visiting farm homes all over the county, told me that she has concluded that a great deal of the neglect of country children is due to the unnecessarily large amount of outside work done by the mothers. Taking care of chickens, for example, if done properly, requires a large proportion of time and considerable expenditure of energy. On some farms, the woman does even the milking and in rarer instances, helps with the chores, morning and evening. Almost all farm women take sole care of the garden. The indoor work, which in addition to a town housekeeper's duties, includes washing, ironing,

baking and churning, ought certainly to end the country housewife's tasks. The outside work could be done by the men.

One of the things that would mean so much to the country mother, if she could only be made to see it, is the great difference that a regular schedule for her children would make in her day. They should of course, have a fixed hour for naps, regular meals and regular bedtime. Children are naturally such little creatures of habit that it is a simple matter, after all, to make them run on schedule. And aside from the obvious benefits to them, this makes the mother's day so much easier. I know that I accomplish more during the hours that my children are having their naps than through all the rest of the day.

A PLEA FOR THE TODDLERS

In one county, a Public Health Nurse makes the rounds of the schools and examines the children periodically. It is not, however, the children of school age who need an advocate. After all, school boys and girls in the country are, perforce, in the open a great deal of the time. They get plenty of exercise; they have clean, rich milk and pure water to drink; and their meals are at fairly regular hours. It is the babies and children under five, who are kept in the house all the winter long, who sleep in airless rooms, eat whenever they think they are hungry, and then eat the sort of food which must slowly ruin their poor little stomachs—these are the ones who need a friend to speak for them.

POPCORN FOR THE BABY

Naturally, as it's the only standard they have to go by, each one of them brings up his or her children according to her mother's methods. In other words, the children live the same sort of life their parents lead. They are also included in the pleasures of their elders. On Saturday nights, for example, they are taken to town, where for hours the men will stand on the corners talking, and the women wander in and out of the stores, lugging a baby usually, with three or four older children following wearily. The baby is not left out of the treat of popcorn, peanuts and candy.

AN INSOMNIA PARTY

Not long ago my husband and I attended a typical evening gathering at a neighboring home in the country. As soon as we stepped into the house, several women rushed up to me and said, "But where are your babies? We were so anxious to see them." Of course I said they were where they always were at that time of night, at home in their little beds. As soon as I had said it, I looked around the room and realized that mine were the only children who were in their beds. In that close, stuffy house, heated by a big base burner, and lit with several smoky oil lamps, a number of children were running about. One baby was being un-

dressed in the kitchen, surrounded by chattering women. He passed through at least three pairs of hands in about five minutes. Of course he was screaming. But there was an easy remedy for that. Food soon quieted him. These women will not believe that it is possible to nurse a child too often. Most of them have their babies sleep with them, letting them nurse at will through the night.

One elderly woman at this same social function said to me, "I understand that you have regular hours for your children to eat and sleep and that you are very strict about keeping to these hours. That's all very well when a person has time to fool with such things, but when I raised my family, I was too busy a woman. When they were hungry, I fed them. They sat at the table with us and ate whatever we did, from the time they were a few months old. And they didn't go to bed until their father and I were ready to go." She said it was a sort of pride. I glanced around at her grown sons and daughters, thin, nervous, sallow complexioned persons, old looking for their ages—and I wondered why she spoke proudly.

Of course, there is an enlightened class in the country as well as in town. This part of the state boasts of some of the finest farms in the state, and many educated and cultured people. Nevertheless, the ignorant and uneducated class exists here also, and among these, there seems to be a crying need for child welfare work. Centers could, perhaps, be established in the district schools, to which it would be easy to persuade the women to take their children.

AROUSING COMPETITIVE INTEREST

Last fall at the county fair, which is the great event of the year, the Red Cross tent, where the county nurse weighed and measured children, was crowded all day long for the four days of the fair. A blue ribbon was given each day to the child who came nearest its correct weight and height, according to age. Although a prize is naturally fascinating to women, I think that most of the mothers who brought their children were actuated rather by the desire to know how nearly their babies attained to a satisfactory condition of health, and to learn how to remedy any defects found.

A child welfare station would arouse this same kind of interest. I am a layman, knowing nothing of the technical details of establishing such a station, but one need not be a professional to see where this work is needed. I believe that the saving of babies is one of the greatest works in the world.

Milwaukee's Health Supervision of School Children

George P. Barth, M. D.

Director of School Hygiene.

TWO years prior to the beginning of health supervision among school children in Milwaukee, the Milwaukee Medical Society appointed a committee who were to undertake a health survey of certain schools in the city covering a period of one month. These schools were selected by the superintendent of schools as typical of the peoples in the several geographical districts. This survey was made and forwarded to the Board of School Directors.

The conditions proved to be such that the Board was galvanized into immediate action, and in April, 1909, a Chief Medical Inspector was appointed, with instructions to formulate plans for a Department of Medical Inspection.

To guide him in this work of organization, the following rules were adopted:

1. The Medical Inspector shall, under the director of the Board and the Superintendent of Schools, have general supervision of the hygiene and sanitation of school grounds and school buildings, and of health and physical welfare of school children, teachers, and janitors, in matters peculiar to the medical profession, and of the manner of conducting medical inspection of schools. He shall appoint, subject to confirmation by the Board, assistant medical and dental inspectors and nurses, and such other assistants as may be authorized by the Board.

2. The Medical Inspector of Schools is the expert advisor of the Board and of its Committees on all questions of school hygiene, and as such shall be privileged to attend all meetings of committees and the Board affecting such questions.

3. He shall perform such other duties as may be assigned to him by the rules of the Board or by the Superintendent of Schools. The Assistant Medical and Dental Inspectors and Nurses shall assist the Medical Inspector in the discharge of the duties devolving upon him. They shall be under his direction, and perform such duties as he may require. The principals and teachers shall see that the rules and directions of the Medical Inspector are properly carried out.

GROWTH OF THE DEPARTMENT

Under these liberal rules, the Department grew rapidly.

The interchange of pupils between public and parochial schools is very free, and previous to the

inauguration of health supervision in the parochial schools, children leaving public school to enter parochial schools, left the jurisdiction of the Medical Department of the School Board, and a great deal of the effort previously expended by doctors and nurses of the Hygiene Department to secure cures or corrections was thus nullified, or careless parents attempted to escape its insistent demands for a proper care of their children by change of school. The control of contagious and infectious disease was also incomplete, because the several children of the same family attended both public and parochial schools.

Milwaukee has 91,988 pupils distributed as follows:

Public Grammar Schools (65)	48,646
Public High Schools (7)	6,584
Trade Schools (2)	994
Parochial Grammar Schools (65)	26,413
Parochial High Schools (1)	125
Private Schools (3)	539
Continuation School	8,687

PUBLIC SCHOOLS AND PAROCHIAL

The argument, that what had proven of such benefit to the public school system, should prove equally beneficial to other schools, prevailed, and on January 1, 1917, health supervision of the parochial schools, under the jurisdiction of the Health Department was inaugurated by the Common Council of the city.

Having two Departments covering the same field and both operating at public expense, proved costly and lacking in efficiency, and in October, 1919, the Departments were combined and placed under the jurisdiction of the Health Department. This resulted in every school in the city being placed under the supervision of one Department.

THE MILWAUKEE SYSTEM

In brief, the system is as follows:

The city is divided into geographical districts. A physician is placed in charge of each district. A regular schedule is provided, whereby each school is visited by the doctor at the same hour and for a definite period of time on specified days of the week. The larger schools are visited three times per week, next largest twice per week, and so forth. Each doctor has from four to six schools in his district, the school population being about 4,000 children.

On reaching the school, the doctor acquaints each teacher in the school of his presence and his readiness to receive children for examination. This is done either by a bell signal previously agreed upon with the principal, or by a monitor system. His work with the children is of two rather distinct types. The first, called morning inspection, comprises examination of all children suffering from any acute disorder. The teacher is privileged to send to the doctor any child who gives any evidence of disease—sores on the face, uncleanliness, general malaise, and so forth—and must send all children who have been absent three days continuously. (In Milwaukee, no child is dropped from the school roll, no matter how long he may be absent, unless it is definitely known that

he has moved from the district.)

Each child bears a blue card upon which the doctor writes his diagnosis and his disposition of the case—referred to nurse, dispensary, whether excluded or allowed to remain in school, and so forth. This card is returned to the teacher so that she may know the ailment of the child and what is going to be done about it. If the child is excluded, he is sent home immediately with an explanatory exclusion notice to the parent, and if the case is one of a reportable disease, it is immediately telephoned to the Division of Contagious Diseases and all precautions against the spread of the disease instituted.

In minor skin diseases—pediculosis, ringworm, impetigo and scabies—full directions for treatment with prescription attached are sent home with each child so afflicted.

FOLLOW UP WORK

When the doctor desires the nurse to do follow-up work on a case, a blue card is left for the nurse, who then takes charge of the case under the doctor's supervision, and by school consultations, visits to the home or to the dispensary, continues the case until a cure is obtained.

To assure proper care all excluded cases are visited by the nurse as soon as possible after the exclusion.

At the conclusion of morning inspection in a school, the doctor devotes the remaining time to physical examinations. The physical examination includes notations on grade, age, date of examination, height in inches, weight in pounds and fractions thereof, nutrition, defective tonsils, adenoids, nasal breathing, palate, teeth, vision, (each eye separately), other eye defects, hearing, (whispered voice), orthopedic defects, enlarged lymph nodes, pulmonary, heart, nervous diseases, speech defects, and special data.

The order of examinations is, first, special cases (cases that may demand special class teaching—vision, hearing, speech, mental, open air—or special physical care), then the kindergarten children, the first, third, fifth and eighth grades in order.

When a more thorough examination is desired, the doctor sends the case through the nurse to one of the specialists of the staff for examination and report.

CARE OF EYES AND TEETH

The Department operates three dental clinics at which children of indigent parents may have their teeth treated free of charge.

The Department also provides glasses free of charge to children of parents unable to purchase them.

An intimate relationship is maintained with all hospitals and dispensaries and the various relief and charity organizations of the city, and a free interchange of reports and cases with the Hygiene Department is practiced.

By order of the Industrial Commission of the State of Wisconsin, all children in Milwaukee applying

for a labor permit must receive a physical examination by a school physician or a regularly licensed physician before such permit is granted. These examinations are made in the school and the advisability of issuing a permit is determined by a consultation held by the principal and the school doctor.

When an examination at the district school is not feasible, the child is examined at the Continuation School. Two physicians are assigned to duty at this school, one man and one woman.

By law, all children working under permit (fourteen to seventeen years) must attend the Continuation School one-half day each week on employer's time.

SCHOOLS VISITED DAILY

The nurses alternate with the doctor in visits to schools so that the larger schools receive a visit from a professional person each day.

The high schools are supervised in the same manner as the grammar schools, and in addition to this service, one physician is detailed to supervise the physical condition of all pupils taking gymnastic work or training for competitive athletics.

Children who are found not to fit in the regular grades are transferred to special classes. These include four day classes for defective vision, one school and one class for defective hearing, four classes for defective speech, five special "C" classes (mentally deficient), forty special "B" classes for backward children, and one school and two classes for open air treatment.

Nutrition Classes are conducted in thirty-three schools with a total enrollment of 4,601 children, and milk and crackers are given to these children at recess periods either free of cost or at ten cents per week, each child receiving crackers and one-half pint of milk.

No distinction is made between schools, whether private, public or parochial, the service being the same in each.

Under the rules of the Board of School Directors, the Medical Inspector examines all teachers applying for leave of absence with pay, and reports to the Board on the advisability of the leave of absence and his opinion as to the length of time which such leave should operate. The Medical Inspector is also the official examiner of the Board of Trustees of the Public School Teachers' Annuity and Retirement Fund.

These are the essential facts concerning the Milwaukee system of health inspection of all schools, whether public or private, a procedure which should in time show splendid results in the prevention of disease, not only among school children, but also in the community at large.

The Pre-School Child and Tuberculosis

Sir Arthur Newsholme, K. C. B., M. D.*

THE highest death-rate of any period of life is in the first five years of life; and in the first year after birth one death out of every twenty-six from all causes is certified to be due to tuberculosis. The real proportion is probably much higher, many deaths returned as due to pneumonia or bronchitis being cases of acute tuberculosis. Landouzy has stated that 27 per cent of the deaths in the first two years of life are caused by tuberculosis. Evidently, in childhood there is but little resistance to the infection of tuberculosis; and if we are to reduce the amount of tuberculosis and to save children's lives *the prevention of exposure to infection during the first four or five and especially during the first two years of life* is of supreme importance.

This inference from epidemiological facts has an important bearing both on general public health work and on special tuberculosis work. It emphasizes the importance of anxious and detailed care in respect to housing for tuberculous adults, including the provision of separate bedroom accommodation, either at home or in a hospital or sanatorium, if for no other reason, to protect young children from an imminent danger. This need for safeguarding the first two or three years of life from infection will remind the public health worker of the similar necessity for preventing children of the same age from acquiring measles, as it is then many times more fatal than later in life. Both child welfare workers and tuberculosis workers will need to act in the closest combination if we are to safeguard infants from tuberculous infection, from which they have not yet had time to acquire partial immunity by gradual and small-dosed infection; and here lies, in my view, one of the most promising and fruitful lines of public health work. * * * * * *

DUTY TO MINIMIZE RISKS, ESPECIALLY FOR CHILDREN

The prevention of tuberculosis depends on increasing resistance to infection and on preventing or diminishing frequency and dosage of infection. We cannot hope in the complex circumstances of modern life to prevent infection entirely; but as the result of increased cleanliness in personal habits and of hospitalization of infectious cases on a steadily increasing scale, infection for most persons is being steadily diminished. It is evidently an act of elementary caution to minimize risks; and such measures as the diminution of uncleanly habits especially in coughing and expectorating, the avoidance of the common use of drinking and other utensils and articles, or of the sleeping in one bed of a tuberculous patient and relatives, are evidently desirable whatever view we may take as to the risk to adults from a consumptive patient. To young

*Extracts from an Address on "Retrospect and Outlook on Tuberculosis Problem."

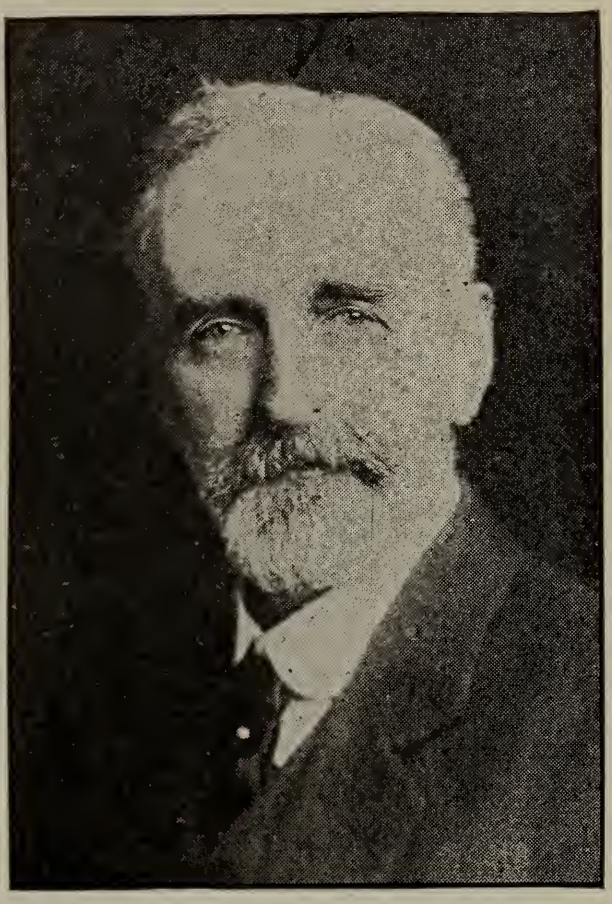
children, such patients with uncontrolled habits, constitute a terrible danger.

At the same time, it is important that the standard of health should be maintained, that good housing should be advocated and secured, that nutrition should be on a high level, and that dirty occupations should be avoided. The two lines of action are not alternative, but mutually complementary and the wise tuberculosis worker will regard them as both bringing grist to his mill. Here, once more, is illustrated the importance of linking up tuberculosis work with general public health work.

Our chief aims must therefore be to minimize infection, especially at the most susceptible ages, and to promote all sorts of child welfare work, and every branch of public health work, which whether by controlling epidemic diseases, by improving housing, or by securing improved occupational circumstance will increase resistance to infection. In short, tuberculosis work is a branch of public health work and must be carried on as such, though, of course, not necessarily by the same workers. * *

In all directions, there is need of extended and more systematic work in every county and every State. With the possible exception of the experimental station at Framingham, I do not think that anywhere the problem of tuberculosis has been tackled on a scale equal to the needs of the case.

There has been too general an



Sir Arthur Newsholme.

impression that when the reporting of cases of tuberculosis has been made obligatory, when laboratory facilities have been provided for examination of sputum, when occasional means for securing an expert medical examination of the invaded family are available, when a public health nurse having a preposterously large visiting list is provided, when here and there a consumptive is treated for many months in a sanatorium, enough has been done to justify us in being surprised at the absence of startling statistical results. We need to think of the work needed in terms which are commensurate with the magnitude of the problem.—[*State Charities Aid Association, February,* 1920.]

MOTHER AND CHILD

A Magazine Concerned With Their Health

Published each month by
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MAY, 1921

A Lesson From History

Many lessons drawn from history are post-mortem conclusions and the fact that history sometimes repeats itself alone makes such conclusions worth while. Social history, and especially the history of child care as described in Payne's "The Child in Human Progress," should be of real value, because the historical problem of the relation of the child to the community and to the state is, and always shall be with us. But what use and what application have the lessons of history to our modern problems; what can we learn from studying the social practices and customs of long ago? These are questions quick to come at the present day when the utilitarian measure is applied to art and literature as well as to science. One lesson, at least, is written over and over again, more and more plainly as knowledge accummulates—and that lesson is the knowledge that poverty and ignorance, and especially the latter, are the chief reasons for lack of progress in child care.

We are accustomed to think that human progress has been what its name would indicate—progressive. That the world has marched on to achievement in knowledge and goodness, each generation improving upon the preceding one. But alas, such is not the case. Human progress has its high peaks and its lowly valleys, its table lands and its morasses. Nowhere is this more apparent than in the history of child care.

Aulus Gellius in the time of Antoninus Pius, wrote of the value of maternal nursing, and Soranus a little while before had indited one of the best text books on the nursing care of the child ever written, before or since, by any single individual. That was a high point of progress. It did not endure. Datheus founded an orphan asylum in Milan in the eighth century, but they had to be rediscovered by Vincent de Paul in the seventeenth century. The Egyptians of Alexandrian days used cow's milk to supplement human milk in infant feeding, but the English were loath to use it even up to the seventeenth century. All this was due to a lack of diffusion of knowledge, a lack of health education, a lack of sufficient propaganda of the right sort, among the uneducated masses.

So it is that one lesson of social history indicates that the very same

forces which today cause El Paso, Texas, to have a very high infant mortality rate and Brookline, Massachusetts, a very low one, obtained in the past, and impeded the march of progress. If Soranus' teachings in the second century could have been spread broadcast among the people, the experience of Brookline would have been presaged if not emulated, in some similar centre of intelligence and economic independence in the dim ages of the past. Instead, the world drifted away from its teachers, became indifferent, and forgot in international jealousies the need of national welfare. We can forgive the ages gone their sins against the child on the score of poverty and ignorance. But to future generations, judging us by our achievements, knowing our national wealth and our means for the diffusion of knowledge, such an excuse cannot be given. This then is the lesson of history—public education is the most important single influence, past or present, in promoting child hygiene. It is not enough to assert that in the domain of child-care this is the most enlightened age in the world's history, and the United States the most enlightened nation. Judged by the test of history we must substantiate such assertions by teaching child health to all our people to a degree really commensurate with our intellectual progress and our national wealth.—JOHN FOOTE, M. D.

A Nursing Problem

In this issue Miss Beard presents the case for the generalized nurse. In an early issue there will appear an article in which this question will be considered from other angles.

A Challenge

The woman of 1850 who wrote "How to Manage a Baby", a pamphlet giving simple, direct instructions to be distributed by the Sanitary Institute of London, blazed a trail followed by thousands. The teachings in books and pamphlets have been reinforced by word of mouth instruction by physicians and nurses in Health Centers, and perhaps best of all by nurses in the homes talking with individual mothers about their own children. Dr. Fulton has shown that, after these seventy years we still lose sixteen out of every hundred babies born before they are five years old, according to the United States Census in the Registration Area for Births in 1918.

In these years since 1850, we have seen that the conditions which end the lives of so many thousands of babies each year, do serious damage to those who live on, maimed, and hurt. We must more than halve this waste of life by setting right the wrong conditions. This is the task of the American Child Hygiene Association. It is our job, and your job. What are you doing about it?

The Day's Work

CHILD HEALTH DEMONSTRATION DIRECTOR CHOSEN

THE direction of this new undertaking in the health field will be under Clarence King, who has had much experience in the field of research and in the administration of civic and social work. He holds degrees from the University of Wisconsin and Columbia University.

With plans under way for coordinating the work of its six constituent organizations which compose it, the National Child Health Council now proposes to press actively its program for a child health demonstration in some suitable community in the United States. It will offer its assistance to such a community in developing a well rounded child health program. The object will be to secure conditions which are as nearly as possible ideal for the development of the children of the community, from babyhood to adolescence, into sturdy, happy, useful citizens.

As a first step a committee has been appointed to select the community from among those which have applied, which consists of Dr. Richard A. Bolt, of Baltimore, general director of the American Child Hygiene Association; Miss Ella Phillips Crandall, of New York, formerly director of the National Organization for Public Health Nursing; Dr. Charles J. Hatfield, New York, director, National Tuberculosis Association; Owen R. Lovejoy, New York, general director, National Child Labor Committee; Miss Sally Lucas Jean, New York, director, Child Health Organization; Dr. Haven Emerson, former health commissioner of New York, and Dr. Donald B. Armstrong, Framingham, Massachusetts.

A test of the soundness and effectiveness of this demonstration will be the permanency of the results in the life of the community. For that reason, the attitude of the citizens and officials toward this health effort will be an important factor in the selection of the community. None will be considered which do not cordially desire such consideration.

It is important that the results of this demonstration should be of the greatest benefit possible not only to the community involved, but to the rest of the country. For that reason the Council wishes to see that the qualifications of the community do not make it strikingly different from the average American community. Therefore the following have been agreed upon:

The town or city should have a population of between 20,000 and 30,000 and should be located in a county of between 50,000 and 60,000 population.

The population should be fairly stable.

The age distribution of the popu-

lation should be fairly near the average, especially as to the percentage of children and babies.

There should not be any strikingly predominant racial stocks.

The city or town should have a normal percentage of its population engaged in manufacturing.

There should be a variety of industries in the city.

The surrounding area should be an agricultural territory.

The town should be in a birth registration state and should have fairly complete vital statistics.

The mortality of infants and children should not be strikingly abnormal. Health conditions should not be abnormally good or bad, and health machinery, including state laws, local ordinances and personnel should be equal to those of a community of similar size.

No geographical limitations are imposed but the Council feels that it is desirable that the community should be fairly easy of access to the Council office and on a main railway line.

Applications are being received from many towns and counties and it is hoped that the right one may be selected within the next month or two.

A CLINIC FOR DEFECTIVE SPEECH

A NEW departure in medical clinics is found in the New York Clinic for Speech Defects, at 143 East 37th Street, New York City. This is the first free medical clinic licensed by the State Board of Charities, that has been organized to devote itself solely to the cure of voice and speech disorders.

The clinic is interested in finding the fundamental causes of the particular speech disorders and for that reason has formed a number of departments to deal with special phases of the work. A medical department takes care of the physical condition of all patients. When diseases of the teeth, mouth and jaw are found to be the cause of the trouble, the patient is put under the care of the dental department. A nervous and mental department takes care of such conditions when they are responsible for or even associated with defective speech.

The various branches of the work of the clinic include the division in the re-educating of patients in an effort to overcome their faulty voice ors peech habits. Also lip reading is taught to those who are deaf, and a public speaking department has been organized for the benefit of the postgraduate patients.

The Defective Speech Clinic is open every afternoon from four until six o'clock so that school children will not have to miss their classes to get the benefit of the treatment offered. It is also open on Monday, Wednesday and Friday evenings from eight until ten thirty to enable working men and women who desire to come for treatment, to do so without sacrificing some of their working hours.

People who have visited the clinic have been interested in seeing how very "unclinical" and inviting a

clinic can readily be. A bright flower box in the window, chairs and easy chairs instead of gloomy benches, a wicker table with the current magazines, a cheerful tint in the coloring of the walls, all disperse the institutional feeling, and give the room an atmosphere that is distinctly different from the traditional dreary one, usually conjured up when one thinks of free clinics in general.

Cooperation with both the medical institutions and lay organizations of the city is part of the purpose of the clinic. Physicians, social workers and teachers refer their defective voice and speech patients suffering from stuttering, stammering, lisping, mutism and every defect of speech articulation, to the clinic for examination and treatment. People suffering from abnormal voice conditions such as aphonia, falsetto voice and others, are cared for.

The social phase of the work has proved to be important in getting the best results. The family and personal history gives a clue to the general status of the patient. After he has attended the clinic and the newness of the atmosphere wears off, a heart-to-heart talk with the director, Dr. James Sonnett Greene, yields results that are amazing.

On taking up treatment at the Clinic, one automatically becomes a member of the Ephphatha Club, the adults belonging to one branch and the children to the junior part of the club. The members hold regular debates on the topics of the day, and lectures are given by the members and outside guests. In all the discussion the principal objective is the attainment of normal speech.—(*Better Times, February*, 1921, *Vol. 2, No. 2.*)

NEW POLICY FOR MOVIES

The National Board of Review of Motion Pictures, 70 Fifth Avenue, New York, is a voluntary reviewing organization which includes a large number of public-spirited men and women, who have given much time to the development of standards. Practically all producers submit their films to this body, paying a fee for the service. But since the board is supported by these fees, the effectiveness of its decisions is ultimately dependent upon the willingness of the producers to abide by them. The Board of Review has greatly improved the quality of motion pictures, and this unofficial method commends itself to those who fear legal censorship. On the other hand, the demand for legal censorship is extensive. The producers have promised a new effort to raise standards, and the Board of Review announces a more stringent policy in the future in enforcing standards. One large producer has threatened that the producers will combat efforts at censorship with an irresistible barrage of propaganda which will make censorship inoperative—a threat which seems likely to increase the demand for

control. Upon application, the Board will furnish its list of approved films. (Information Service, Research Department, Federal Council of the Churches, March 15, 1921.)

BABIES' HOSPITAL OPENING

The Babies' Hospital of Philadelphia will be formally opened May 9 and 10, 1921. The lofty endeavor of this hospital is to prevent the onslaught of disease—to keep babies well. There are beds and laboratories for scientific research, and for emergency work, but the highest ideal of the hospital is to interpret the spirit of preventive medicine; not only to provide beds for the relief of suffering and the cure of disease, but to be a teaching center for all the neighborhood, which, in the City of Brotherly Love, includes every home in which there is a baby needing care. Instead of many wards with their usual hospital equipment, there are many rooms for class instruction and demonstration in which mothers may learn not only the essentials of infant hygiene, but may have pre-natal instruction. There will be visiting nurses in the homes and social workers whose constant endeavors will be to better the home conditions.

The formal dedicatory exercises will begin on the afternoon of May 9th. The president of the hospital, Dr. Charles A. Fife, will preside. The chairman of the Building Committee, Mr. Fred A. Rakestraw, will turn over the building to Mr. Howard A. Loeb, the Chairman of the Executive Committee. Addresses will be made by Hampton Moore, Mayor of Philadelphia, and others. Monday evening the subject of discussion will be "The Relation of a Babies' Hospital to the Child Welfare Work of the city." Dr. H. L. K. Shaw, President of the American Child Hygiene Association, will make the principal address. Tuesday afternoon the Medical Social Service Committee, under the chairmanship of Mrs. Charles F. Jenkins, will have charge. Mrs. William Lowell Putnam, of Boston, and Dr. Philip Van Ingen, of New York, Dr. John A. Foote, of Washington, will speak. The Tuesday evening meeting will be the May meeting of the Pediatric Society of Philadelphia, which will be held in the Hospital. Dr. Maynard Ladd, of Boston, will speak on "The Medical Supervision of Children in Foster Homes." Mr. J. Prentice Murphy, of Philadelphia, will read a paper on "The Need of Medical Service for Dependant and Neglected Children." Dr. John Donnelly will give the closing paper of the evening.

MATERNITY BENEFITS

The former maternity bills have been withdrawn. A new bill, appropriating $35,000 to be used, in educating mothers, and district nursese in maternity care, is still before the committee. [Boston Transcript, March 21, 1921.]

Coming Conferences and Meetings

THE following conferences and meetings will be held:

May

2-6—**International Kindergarten Union, Detroit.**

7-8—**American Academy of Political and Social Science, Philadelphia.**

June

3-5—**State and Provincial Health Authorities of North America.**

6-10—**American Medical Association, Boston.**

13-17—**National Tuberculosis Association, New York City.**

13-28—**An Institute for the Training of Nutrition Workers** will be conducted under the auspices of the Elizabeth McCormick Memorial Fund in Chicago, Illinois. Dr. William R. P. Emerson, of Boston, will give the lectures and class demonstrations, assisted by members of the staff of the Elizabeth McCormick Memorial Fund. The fee for this course will be fifty dollars. For information, write to the Elizabeth McCormick Memorial Fund, 6 North Michigan Avenue, Chicago.

22-29—**The National Conference of Social Work** will be held in Milwaukee, Wisconsin. The final program of the Division on Health is as follows:

June 23—9.00 to 10.55 A. M. Cooperation and Coordination in Health Work.

1. The National Health Council — Organization and Progress.—Donald B. Armstrong, M. D., Framingham, Massachusetts.

2. National Child Health Council—A Council for Coordinating Child Health Activities.—Courtenay Dinwiddie, Executive Secretary, National Child Health Council, Washington, D. C.

3. How can Voluntary Organizations best cooperate with Health Officials?—Sherman C. Kingsley, Cleveland Welfare Federation, Cleveland, Ohio.

June 24—9.00 to 10.55 A. M. The Health Program of the American Red Cross.

1. The Social Significance of Health Centers.—Philip S. Platt, Director, New Haven Health Center, New Haven, Connecticut.

2. Cooperative Health Plan of the New York County Chapter, American Red Cross.—George R. Bedinger, Director, Health Service Department, New York County Chapter, American Red Cross New York City.

3. Public Health Nursing Program of the American Red Cross.—Elizabeth Fox, R. N., Director, Public Health Nursing, American Red Cross, Washington, D. C.

June 27—9.00 to 10.55 A. M.

Social Significance of Child Health Work.

1. Education in Health Habits.—J. Mace Andress, Ph. D., Boston University, Child Health Organization of America and Bureau of Education.

2. What State Divisions of Child Hygiene are doing to promote Child Health.—Ada E. Schweitzer, M. D., Indiana State Board of Health, Indianapolis.

3. Relation of Hospital Social Service to Child Health Work.—Ida M. Cannon, Social Service Department, Massachusetts General Hospital, Boston, Massachusetts.

June 28—11.00 to 1.00.

Government Departments in Their Relation to Health.

1. The United States Public Health Service.—C. C. Pierce, M. D., Assistant Surgeon General, Washington, D. C.

2. The Children's Bureau.—Anna E. Rude, M. D., Director, Division of Hygiene, Children's Bureau, Washington, D. C.

3. Department of Agriculture, Extension Service in Home Economics.—C. F. Langworthy, Ph. D., Department of Agriculture, Washington, D. C.

4. Bureau of Education.—Willard S. Small, Ph. D., Interdepartmental Social Hygiene Board, Washington, D. C.

June 29—9.00 to 10.55 A. M.

Certain Elements in a Health Program for Children.

1. The Significance of Nutrition in bringing the Undernourished Child up to Standard.—E. V. McCollum, M. D., and Nina Simonds, School of Hygiene and Public Health, Johns Hopkins University, Baltimore.

2. Where should this Nutrition Service next be centered; in the School; in the Child's Own Family: in the Home?—Mrs. Ira Couch Wood, Director, Elizabeth McCormick Memorial Fund, Chicago.

3. The Modern Health Crusade and the Nutrition Movement.—Charles M. DeForest, Crusader Executive, National Tuberculosis Association, New York City.

The Foreign Field

Northern France

Commission for Relief in Belgium and Northern France

W. B. Poland

IN April, 1919, it was evident that conditions had again become sufficiently normal to justify the C. R. B. in winding up its work of feeding the 2,000,000 people of the occupied regions of Northern France, which had been undertaken in 1915 at the request of the French Government and was continued at their request after the Armistice.

It was also foreseen that the charitable activities of the Commission should be terminated so far as concerned direct intervention by an American staff. In accordance with the policy always insisted upon by Mr. Hoover, that the actual work should be carried out by a personnel of the country, and in order to avoid interruption when we withdrew, definite steps were taken to place the C. R. B. benevolent activities exclusively in the hands of the French.

The Comite d'Assistance des Regions Liberees d'Accord de la C. R. B. was therefore organized with Mr. Hoover as Chairman and Mr. Poland, Mr. Rickard Mr. Shaler and Mr. Tuck, Directors, and Mr. Chevrillon, Treasurer, representing the American group; Monsieur Labbe and a distinguished body of French doctors and men of affairs representing French interests. Regional Centres were established which, in turn, organized local distribution committees, composed in large part of those who had been identified with the C. R. B. organization for the past four years. The Regional Directors formed an Executive Committee with M. Labbe as President.

Monsieur Labbe was Chief of the Executive Committee of the Comite d'Alimentation du Nord de la France during the terrible years of German occupation, and after the Armistice was President of the Comite de Ravitaillement des Regions Liberees. He is now Director of Education of the Liberated Regions. Dr. Lambert, one of France's celebrated surgeons, is Manager. Dr. Osset, a distinguished doctor for children, has special charge of the "Consultation Nourisson". Senator Dron, who is also Mayor of Tourcoing widely known for his influence in the affairs of the North, and in large part the originator of the "Consultation Nourisson", is another member of the Executive Committee. M. Chevrillon, Treasurer, devoted C. R. B. representative in France during the whole war period, althought a Frenchman, represents the Commission directly upon the Executive Committee.

M. Paul Beri, for two years representing the French Government as liaison officer to the Commission for Relief in Belgium, and at present Assistant Director of the Credit

Commercial de France, is a member.

Other members of the Executive Committee and a small paid staff are persons of the highest standing and devotion to relief in the Liberated Regions.

In June, 1919, the benevolent work which had been carried out by the C. R. B. largely through the men and women who afterward became associated in the Comite d'Assistance, was definitely turned over to this organization. This work consisted principally of *Gouters Scolaires,* a supplementary meal of biscuits and cocoa given to 40,000 or 50,000 French children; *Child Clinics* by means of which children were examined, washed, freed from parasites, assigned medical treatment—or more usually special diets to counteract the effects of malnutrition; *Assistance Discrete,* by means of which sums were distributed to members of the ruined families of the Devastated Regions to assist them to become once more self-supporting; *Special Relief* measures.

In 1919 some 7,000 children and in 1920, over 10,000 children were sent to health camps along the North Coast where they received medical attention, a diet to counteract their years of under-nourishment and were also given a certain amount of school instruction. The way in which they recovered under this treatment was a matter of wonder. The results were so good that this work has not been taken over by the Government.

In 1920 "Consultation Nourisson" was started all over the Liberated Regions. This concerns itself with the care of very young children from birth to about 18 months or two years, as well as care of mothers. The mothers receive expert medical advice and a donation of food, money or medicine, as the circumstances require. The cost works out to about twelve to fifteen francs per child per month, and the results up to date, in reducing infant mortality have been remarkable.

In the Liberated Regions of France as of December 1, 1920, there were 441 "Consultations", at which were employed 383 doctors, 120 nurses, 435 "Sage-Femmes", 392 secretaries; a personnel of 1,330. There were 34,000 children being cared for at these centres at a total cost to that date of Fr. 4,526,000.

Other expenditures for Gouters, Vacance Scolaire, Child Clinics, Assistance Discrete, and Special Relief, have amounted to Fr. 5,676,412, making a total already expended of Fr. 10,203,000. The funds which have been made available to December 1, 1920, through the Comite d'Assistance and the earlier distributions of the C. R. B. Benevolent fund amounted approximately to Fr. 26,595,000, of which a balance remained of approximately Fr. 16,392,000.

The results obtained by the "Consultation Nourisson" in the reduction of infant mortality, the raising of a standard of child life, and the

education of the mothers, are so remarkable that it has been strongly endorsed in the French Assembly, a resolution of thanks to Mr. Hoover having been passed by that body. Members of the Executive Committee have strong ground to hope that the whole or a portion of this work may be taken in charge by the Ministry of the Liberated Regions and that eventually it may be spread all over France, a splendid endorsement of the Comite's progressive work, made possible by the C. R. B. (American Relief Administration Bulletin. Series 2, No. 10. March 1, 1921. p. 21.)

Japan

Saving Japanese Babies

After a visit to this country, Arthur Black, Honorary Secretary of the Shaftesbury Society, made the following statements on child welfare work as conducted in Japan:

"A report issued by the Social Work Bureau of the Home Departmen gives some interesting details of the present condition of the Child Welfare Movement. The provision for children of school age is much more complete than for infants. Elementary schools accommodate almost all the normal children—with high average attendances. Special agencies, helped by public grants, deal with many of the blind, deaf and dumb, and neglected children. There are over seven hundred charitable agencies concerned with orphan and otherwise necessitous children and adults. Medical inspection takes place in more than half of the twenty thousand schools accommodating seven million scholars. There is, however, no scheme for treatment, and much unrelieved suffering and disease is the fate of tens of thousands of tuberculous and anaemic children from overcrowded and insanitary areas. Japanese birth and death statistics afford striking contrasts to those in Western lands. Births have increased from 1,058,000 in 1885 to 1,737,000 in 1910—and the rate of increase of population is from 7.8 to 13.4 per 1,000, the present annual addition being about 700,000. Yet the infantile mortality still averaging over 150 per 1,000 shows no sign of decline.

Efforts to tackle this vast problem of infantile death so far have been but slight. Lectures to women on child care, and the formation of Young Women's Associations with over a million members, are recent and most hopeful features. Two private Infant Welfare Centers have been started, and there are fifty day nurseries for three thousand children run at an annual cost of only 9,000 pounds.

This infant wastage is not due to maternal neglect. It is agreed that the Japanese, however ignorant of the laws of child nurture, are devoted to their children, who are clean and neatly dressed and kept free from vermin; the homes, too, if poor and cramped, are tidy. The high infant mortality would

appear to be largely due to the status of woman in the social order, to early marriage, to the excessive burdens borne by girls, and to the general low economic level of working-class life. With the gradual emancipation of women will come their entrance into those spheres of administrative action concerned with child health and efficiency that will mean increased provision for maternity and infant welfare. The whole subject is to be investigated by a special committee of the Home Department, and we may look to Japan for bold and comprehensive plans to ensure for the children of the nation an unimpaired heritage for body and mind. (National Health, March, 1921.)

Poland

A School Garden Army Overseas

Modeled along the lines of America's School Garden Army, is the force of Polish children formed a year ago by the Junior American Red Cross when that organization was called upon to bring relief and cheer to the children of Kosciusko's land. With the first warm, spring days thousands of youngsters in Poland gathered up their hoes, rakes, and spades and advanced upon vacant lots, determined to convert them into vegetable and flower gardens.

Of the many things which the Junior American Red Cross introduced to the children of Poland, the community garden made the strongest appeal. It not only gave the children a chance to take up gardening, but also provided healthful recreation for thousands of stunted, undernourished little bodies fighting an unequal battle with disease in the crowded capital of Poland. In addition, it helped keep the wolf of starvation away from many a home.

Eight widely separated garden plots near the most populous districts in the city of Warsaw were secured. Committees of school principals and teachers were organized. The heads of orphan homes were brought in. Then the Junior Red Cross, in the name of the school children of America, shipped 10,000 garden tools to Poland, and these were distributed among the schools and orphan homes. Seeds in large quantities were also sent from the United States. Six professional instructors were appointed and each of these in turn was assisted by five volunteer supervisors, members of the Garden Propagation Circle of Warsaw.

The children enlisted in the Garden Army in Warsaw raise potatoes, beets, carrots, cabbage, parsnips and beans. Their fall crop in 1920 was 93 tons. They raised 40 tons of potatoes, 20 tons of beets, 15 tons of cabbage, 10 tons of carrots, 5 tons of beans and 3 tons of parsnips.

The success of the Warsaw Gardens last year was so pronounced that the plan has been extended to other centers this spring. To stimulate interest in the gardens, they are

operated on the competitive basis as in America. Prizes are awarded to the most productive plot of all the gardens and to the individual of each garden who raises the most produce. The result is keen competition for the coveted prize which takes the form of blue ribbons issued by the Junior American Red Cross.

There are no more enthusiastic followers enrolled under the Red Cross banner to be found in Europe than these youthful gardeners of Poland. (Junior Red Cross Service, May, 1921.)

Germany

The Value of Baby Centers

The Infant Welfare Society of the district of Munich recently made a study of the statistics in regard to children whose mothers received State maternity benefits to see whether those babies who were under the care of welfare agencies fared any better than the rest. It was found that almost three-quarters of the 10,000 infants born in Munich in 1915 were under the care of welfare agencies. Of this number, 66.3 per cent were breast-fed, while the proportion of those not in the care of the agencies who were breast-fed was 23.5 per cent. The mortality rate of the babies under the care of the agencies was 114 per 1,000 as against 149 per 1,000 for the entire city. (Zeitschrift fur Kinderschutz und Jugenfursorge, November, 1920.)

England

The Value of Playgrounds

As a matter of economy, the London County Council has decided not to open vacation play centers during the summer months of 1921. Last summer 2,000 pounds was appropriated for play centers in the parks and playgrounds. The London Times criticizes the Council severely for this action: "To save this sum the London County Council this year is not only depriving hundreds of thousands of children of sound, healthful recreation, but is exposing them to the moral and physical dangers of the streets." (London Times Editorial Supplement.)

In connection with social betterment, and with the provision of open spaces for amusement, a very interesting investigation was carried out a few years ago in Liverpool. Careful maps of the city were made, showing the houses in which juvenile crime occurred. On investigation, it was found that the prevalence of crime depended, not on the social conditions of the house, not on the wages that went into the house, but almost entirely on the proximity of the house to a public park. No matter how small and mean the houses, if they were close to a public park, juvenile crime at once disappeared. Where access to the public park was very difficult or impossible for the children, juvenile crime reached its maximum. (National Health, March, 1921.)

Recent Literature on Mother and Child Welfare

Book Review

Red Cross Course in Food Selection, American Red Cross, National Headquarters, Washington, D. C. Price, 50c.

The American Red Cross has just issued a new course of study in Food Selection. The lessons have been written primarily for Red Cross classes in Food Selection, but can be used by all women who are interested in the problem of feeding the family. The course embraces a study of foods and the factors that must be considered in selecting an adequate diet. It aims to give a knowledge of foods and food groups which will enable the housekeeper to modify her selection of food to suit the needs of the individual members of the family. The lessons include quite full discussions of such topics as food and its use in the body, the more important food materials such as milk, vegetables and fruits, and cereals. One lesson gives a convenient method for the calculation of the dietary, another discusses feeding in special cases, including feeding in illness. The subjects of infant feeding and food for the child from two to sixteen years of age receive considerable attention.

As was stated above, the lessons are intended for use in the Red Cross classes in Food Selection, and it is expected that the instructor will contribute much to their value. At the same time the person working alone will be able to comprehend most of the subject matter, and also to review each lesson in the light of the topics suggested for class discussion, although it would be better, of course, to seek the assistance of a teacher of Home Economics or a Home Demonstration Agent.

The home work assigned in connection with each lesson will be helpful to any housekeeper who is of an investigative turn of mind. Detailed suggestions for demonstrations, also valuable food tables are contained in an appendix. Supplementary to the lists of bulletins given in connection with the lessons there is a brief annotated bibliography of books of reference.

Books and Pamphlets Received

A Synopsis of the Child Hygiene Laws of the Several States, Including School Medical Inspection Laws.—Clark, Taliaferro, Surgeon, United States Public Health Service, and Collins, Selwyn D., Assistant Statistician, United States Public Health Service. Public Health Bulletin No. 110, November, 1920. Treasury Department. pp. 58.

The Canadian Mother's Book.—Department of Health, Ottawa, Division of Child Welfare, Helen McMurchy, M. D., Chief. 1921.

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5. Venereal Disease.
6. Mental Diseases and Mental Deficiencies.
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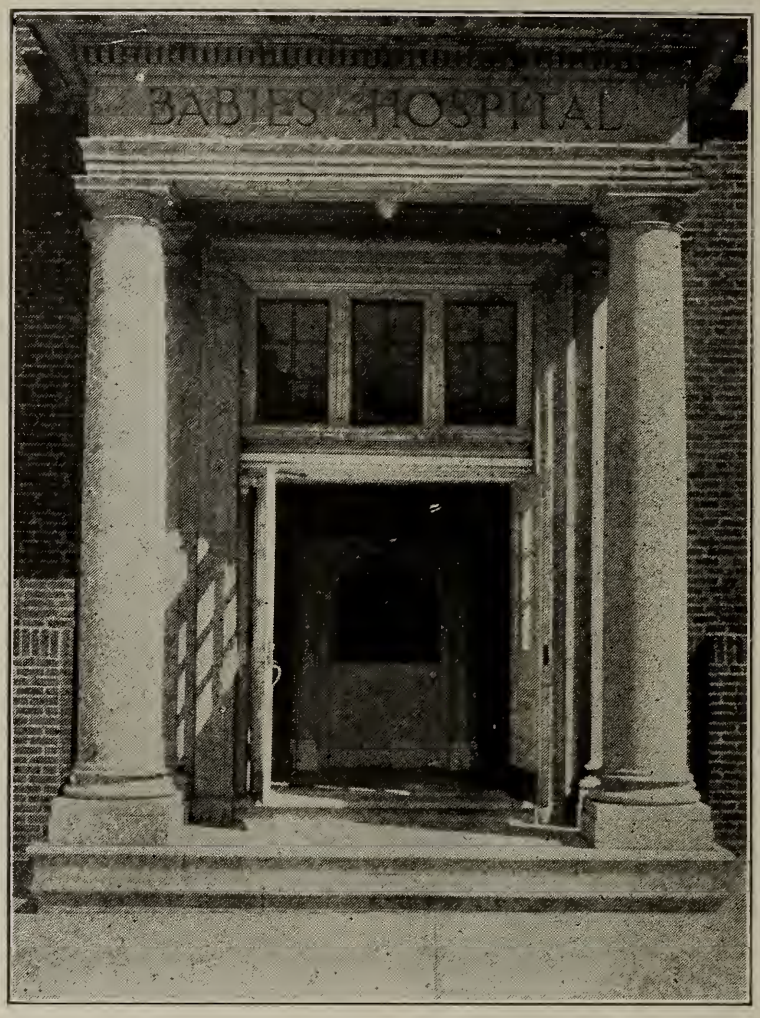


The New Building of The Babies' Hospital of Philadelphia is not a hospital, nor a clinic, nor a community center, nor a convalescent home, but it is the center of a system embracing all these important phases in the conservation of child life. This center with its city clinics and follow-up work, its country hospital for sick babies, and sea-side home for convalescent babies and their mothers, offers a unique contribution to the health-building machinery of Philadelphia. The Babies' Hospital is a center from which health education radiates.

MOTHER AND CHILD

A Magazine Concerned With Their Health

VOL. II JUNE, 1921 No. 6

"Keep Us Well" Is Our Slogan

Planning the Child-Health Station

LeRoy A. Wilkes, M. D.,

Medical Director Public Schools, Trenton, N. J., Formerly Director Child Hygiene, Department of Health, Bridgeport, Connecticut.

THE aims of the Child Health Station should be the raising of the physical standard of the child of whatever age, from before birth to the time when he leaves the school, in the majority of cases, to enter his life work, and in too few of the cases to obtain further preparation for the same purpose.

We may group the desirable activities of the work under the following divisions which have come to be accepted as practical:

1. Prenatal Care, which includes the regulation and control of Midwifery, especially in districts having a rather high per cent of foreign population.

2. Natal Care for *every* expectant mother—the best care the community can afford, regardless of the financial status of the applicant. A woman who is with child is entitled to the *best* that a community can provide, both in justice to herself, and for the ultimate economy of the community.

3. Post Natal and Infant Care can be carried on at one and the same time. The mortality in these groups has already been so markedly reduced as to demonstrate the practicability of enlarging the scope of the work.

4. Pre-school Age Supervision and Care. This much-discussed, but little acted upon, group is an extremely important one, and the Health Station plan, I believe, will best provide the adequate care which this group so badly needs in so large a percentage of cases.

5. School Age. This group has received more attention than any other age-group in the life of the child. Standardization of certain

fundamental procedures is desirable, but we must always provide enough elasticity to allow for local conditions. Too many failures result from the attempt to bend a town or city to fit a system which has given satisfaction elsewhere.

6. The examination of applicants from fourteen to sixteen years of age to go to work. The variation in the routine of examination of these older children, and the laxity and indifference shown by some examiners I have seen, is deplorable. This is a *very important phase* of the child's life—the encounter with the battle of life in the trying period of adolescence.

The Child-Health Station, in the larger cities, should be a branch office of the Health Department, Division of Child Hygiene. The care of the School-Age Group, in the opinion of the writer (who has had a number of years' experience under both conditions), is best conducted under the Board of Education—unless that body be an inefficient one—because of the unconscious psychology of the average teacher who has a tendency to regard the doctor or nurse employed by the Department of Health as an "outsider", while the same persons under the authority of the Board of Education are at once looked upon as "our" doctor and nurse who will help us with "our" exceptional children that are "our" burden (in many cases).

LOCATING THE STATION

It is evident that the Station must be located as near as possible to the center of the district it is to serve. But lack of funds, or other reasons may make it necessary to select a building which might be obtained rent-free. A schoolhouse may have a vacant room, preferably two or three rooms. The *location* of schoolhouses is known to everyone in a town or city. This fact is of considerable value in the foreign quarters of a community. Here not only rent, but often heat and light, may be obtained with permission of the school authorities, at little or no cost. Good light and heat are essential in the Health Station. Convenience to car lines is usually provided by the selection of school buildings as sites for the Stations.

Most towns and cities are divided into districts, for political and other purposes, and a study of the morbidity and mortality rates in each district with especial reference to the age-groups concerned in the work of the station, will help decide the first district in point of urgency of need.

Birth registration, infant mortality, marriage records, school census reports, and so forth, are public records available in most cities. Other data can be obtained directly, by questionnaires taken home by the children for parents to fill out and return. This last method has been tried out by the writer in a school system of 30,000 pupils, and the response was even better than he had dared hope it would be. If there is a visiting nurse association (under whatever name), great assistance can be obtained from their

cooperation in getting necessary data in any neighborhood. Church organizations, ministers, priests, rabbis, postmasters, Chambers of Commerce, Rotary, Kiwanis, Civitan and other business clubs will aid if their aid is sought in a definite program.

The rooms are best finished in white or cream enamel so they can be washed down and kept clean and sanitary. Light colored, washable curtains add to the room, as do other touches, and give to the Station a home-like air. Heavy non-folding chairs or benches that will not tip over with the active child, are necessary — old church pews bought at second-hand shops, or benches made by a local carpenter and covered with canvas to prevent splinters, have been found to be satisfactory and cheap.

NECESSARY EQUIPMENT

There should be at least two or three large kitchen tables for examinations and records. Filing boxes are needed to hold the records of the station. Screens with washable curtains help to divide a room and add privacy to the examination. They should preferably have four panels.

Three types of scales will save time in a large station. One is a large scale with the capacity of 300 pounds, by quarter pounds, with a measuring rod from two feet six inches to six feet six inches range in height. A scale of fifty pounds capacity with ounce divisions is good for the pre-school age child.

Baskets for Babies' Clothes

This should be elevated so that the face of the child being weighed shall be on a level with the face of the person weighing—or the mother can stand near if the child is afraid. This point is a time-saver. A padded basket may be used with this scale to weigh babies when proper adjustment is made, but a spring baby-scale of 25 pounds capacity will save much time when many babies are to be weighed. A measuring trough for babies may be bought, or can be made by a local carpenter.

An ordinary market basket tied to the back of each chair will hold the clothing of the babies. A fresh oiled paper napkin should be placed in the basket for each baby.

Along one wall space can be placed a number of shelves for an outfit to prepare modified milk; a baby's layette; literature, which can be obtained free from the Government, and a number of state and local Health Departments, and private agencies, on "Care of the Baby", "Care of the Pre-School Child", "Care of the Expectant Mother",

Home-made Refrigerators, All About Milk and other Foods, Child Labor Laws, and so forth. Health posters can be made by cutting out illustrations from advertisements in the magazines and printing suitable captions below them; or posters may be purchased.

Blood pressure outfits for the examination of expectant mothers will be needed, but the doctor will in all probability supply his own outfit.

Demonstration outfits for Little Mothers' Leagues can be added as classes for instruction are formed in the Health Station.

The furniture should be so placed about the room as to "route" the parents in an orderly fashion to the various workers and allow the "waits" to come at the points where the exhibits, posters, and so forth, are conspicuously displayed. Thus the inevitable delays are put to good purpose and tediousness is kept at the minimum.

Provision must also be made to have the Station kept scrupulously clean and sufficiently warm to allow the children to be undressed without the danger of catching cold.

Some Little Italian Patients

ORGANIZATION OF THE STAFF

The staff must correspond to the scope of work undertaken at each Station. For a good-sized Station it will be essential to have a good physician who can give adequate time to the work without being rushed. Hence, he should be paid for a definite time to be spent in the work. A physician whose personality makes him popular and successful with children, and who is regular in attendance at the Station at the time designated, is very essential to the success of the Station.

An experienced Child-Welfare Nurse, familiar with the best procedures in use at the present time for the various age-groups, should have charge of the Station and be responsible only to the head of the organization conducting the Station. It is unnecessary to state that the closest cooperation must mark the work of this nurse and the doctor. Assistant nurses must be provided as needed, both in the Station and to adequately "follow-up" the cases at home.

Volunteer workers must be *regular* in attendance at the Station, and must work under the direction of the Nurse-in-Charge.

CONDUCT OF THE STATION

Demonstrations and talks by the doctor and nurses should be scheduled and given at stated times at the Station, and the individual needs of the child should be discussed with the parent at each visit to the Station and to the home. Full

records of the child's growth and condition should be made at each visit. The children should be undressed and wrapped in blankets when taken in turn to the doctor for examination.

Expectant mothers should visit the Station for blood-pressure records, and discussion of symptoms with the doctor bi-monthly. Urinalysis may be made routinely each month, or oftener when deemed necessary. Measurements and examinations, especially in first pregnancies, should be made in a Prenatal Clinic, or by the family doctor, in each case.

School children will be examined and advised at regular periods by the medical inspector at the schools. In smaller places where no other provision is made elsewhere, these examinations can be made at the Station. Where provision is made for these examinations elsewhere, they may be omitted at the Health Station. Examination of children about to go to work should be thorough, and the applicants divided into some such groups as are herein suggested.

(a) Normal Child. Can work with only such restrictions as are provided by the Child Labor Laws.

(b) Defective Eyesight (one-third vision, or less, in both eyes). Cannot work about power-driven machinery.

(c) Anemic and Malnourished Child (apparently otherwise in fairly good health). Restricted to outdoor work and a limited number of hours per day. Re-examined at stated intervals, and effect of work noted and restrictions modified in accord with effects noted.

(d) Severe defects or chronic disease may totally prohibit child from obtaining and holding any position.

A Group of Hungarians

Examination of adults and preventive advice may, of course, be added to the above, where it is thought practical.

A study of the traits and habits of certain foreign groups will help in the understanding necessary to obtain the greatest amount of cooperation of parents in correcting those habits believed to militate against the health of the child. The work of the Health Stations should be correlated with that of social, medical, nursing, religious and other organizations and agencies in the community, to avoid duplication of effort and to further mutual understanding. The writer had the privilege of organizing, establishing and conducting three such Health Stations which were so successful from the start that three additional Stations were soon found necessary.

Pre- School Age Physical Defects

John C. Gebhart

Director, Department of Social Welfare,

New York Association for Improving the Condition of the Poor

THE clinics for examining apparently well children, which are conducted twice a week by Dr. Louis C. Schroeder, are an essential feature of the community health work of the Association for Improving the Condition of the Poor.*

From April, 1919, to October, 1920, the number of children examined was 2,186, of whom 894 were of pre-school age (roughly from two to six) and 1,076 were from six to twelve, while 216 were from twelve to eighteen. We are particularly fortunate in being able to present the records of so large a number of children from the same neighborhood, all of the same racial stock, many of them from the same family, and all of them examined by the same physician. The age divisions of this homogeneous group give us a fair basis for comparing the physical defects of the child of pre-school age with the child of school age, and of comparing both these groups with a group of older children who are about to enter industry.

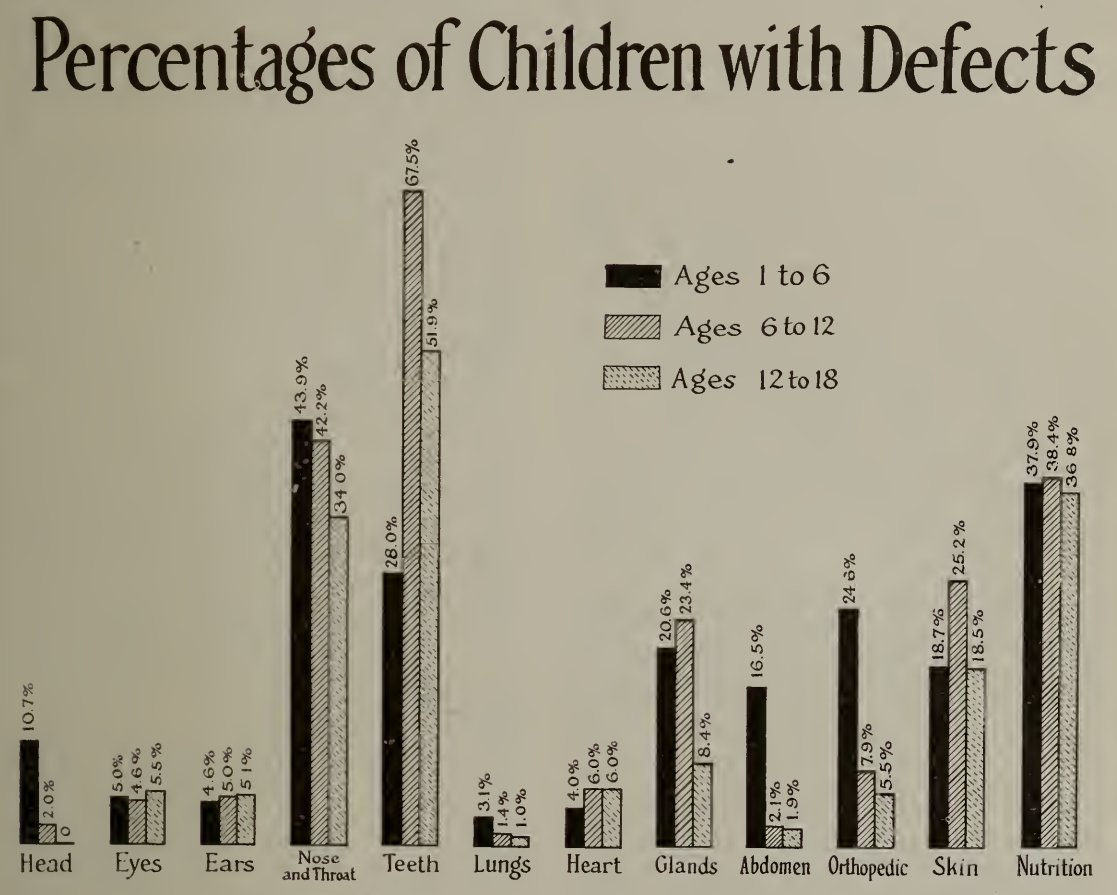
A careful study of the examination cards used by other workers dealing with similar groups, indicated that many of them included defects which Dr. Schroeder regarded as unimportant, while others which he regarded as most important were omitted. We then decided to make a list simply of the main subdivision of defects: head, eyes, ears, nose, throat, teeth, lungs, heart, glands, abdomen, orthopedic, skin, genitals and nutrition. The nurse who assisted the doctor was supplied with this list and noted opposite each main heading, the exact defect which Dr. Schroeder found. These defects were grouped and classified and insignificant ones omitted in the present tabulation given on page 249. Since this schedule was evolved out of our experience with a particular group, and is not exactly like any other schedule in existence, comparisons of the defects found here with those found by other observers must be held in abeyance until we have examined our results in some detail.

RATIO OF DEFECTS TO AGE

The total number of defects found among pre-school children (from one to six) was 2,231 or 2.5 defects per child; the total defects for the next group (from six to

*For a complete statement of the aims and scope of this program, see "Mother and Child", August, 1920, Vol. I, No. 2, page 88.

twelve) was 2,553 or 2.4 defects per child, while the total defects in the older group was 391 or 1.8 defects per child. There was thus a constant decrease in the number of defects with advancing age. A different tendency was noted, however, in the number of children having defects. In the pre-school children 87 per cent had defects; in the next group (six to twelve) 92 per cent had defects, and in the last group (twelve to eighteen) only 87 per cent had defects. This means simply that although there was a slightly higher immunity among the pre-school group, those who had defects had more of them. While the incidence of defects was obviously higher in the pre-school group, the mere number of defects was of little importance unless we knew what the defects were and their relation to the physique and well-being of the growing child. The accompanying table indicates graphically the relative prevalence of various defects in each age group.



Defects of the Head—These are mainly rachitic and were much higher among the pre-school age, for in that group 10.7 per cent had such defects as against 2 per cent in the next group, and none in the oldest group.

Eye Defects—There was, on the other hand, little variation in the number of children with defects of eyes. In these defects, however, with the exception of strabismus and two cases of blindness, no notation of errors of vision were made. In the pre-school group, 5 per cent, in the next 4.6 per cent, and in the last 5.5 per cent of the children had

eye defects. From 4.5 per cent to 5 per cent of the children of each group had ear defects. Chronic otitis media constituted 90 per cent of the defects found.

Defects of the Nose and Throat—Coryza, rhinitis and purulent discharge were much more prevalent among the children of pre-school age, for 4.9 per cent of the children of this group had defects of the nose as compared with 2.2 per cent of the group from six to twelve, and 2.2 per cent of the group from twelve to eighteen. Defective tonsils, of which 96 per cent were hypertrophied, the other defects being either congested or ragged tonsils or acute tonsilitis, were about as prevalent among the middle group as among the pre-school age; the three groups ranked as follows with respect to the percentage with defects: 39 per cent, 38.8 per cent and 35 per cent. We grouped the nose and throat defects together because hypertrophied tonsils are almost always accompanied by hypertrophied adenoid tissue. This gave us the first high peak of defects 43.9 per cent for the pre-school group, 42.2 per cent for the older group, and 34 per cent for the oldest group. The number of cases where removal of hypertrophied tonsils was advised was less in the pre-school group than in the older group; not so much because the defect was less serious, as that surgical interference with the younger children seemed inadvisable except in the most extreme cases. In the pre-school group, removal of only 27 per cent of the defective tonsils was advised, as against 43.7 per cent for the next group, and 48.3 per cent for the oldest group.

Defective Teeth—Even a very superficial examination which considered only gross conditions, revealed 28 per cent with defective teeth for the pre-school group, 67.5 per cent for the older group and 50 per cent for the oldest group. A careful examination of the children of school age in our dental clinic in this district showed that 96 per cent of the children of school age have defective teeth.

Lung Defects—While these defects did not bulk large numerically, they were most significant. One case of pulmonary tuberculosis was found in the pre-school group and another in the group from six to twelve. There were twenty-four cases of bronchitis and one case of unresolved pneumonia in the pre-school group. All cases which showed any chest signs which were suggestive of tuberculosis were referred to a tuberculosis clinic for continued observation. (Several such cases are now under observation, the results of which are not included in this report.) In the pre-school group, 3.1 per cent, in the next group, 1.4 per cent, and in the last group, 1 per cent of the children had defects of lungs.

Cardiac Defects—The percentage of children with such defects was much higher than is usually found; for 4 per cent of the pre-school and 6 per cent of the two older groups had cardiac defects, while the Health Department of New York City reported only 1.6 per cent of the school children as suffering from such defects. The larger number of cardiacs in our group was due partly to the inclusion (for purpose of observation) of cases of functional murmurs. If we omit functional murmurs entirely, 1.8 per cent of the pre-school, 2.4 per cent of the next, and 5.2 per cent of the oldest group had serious cardiac defects.

Defects of Glands—This was the next peak in number of defects found. The pre-school group was a little lower than the next group, with 20.5 per cent of the children defective as against 23.4 per cent. In the oldest group the percentage with defects fell to 8.4 per cent. Defects of the axillary and tonsillar glands increased with age, while those of the cervical and epithrochlear decreased with age.

Abdominal Defects—Defects of the abdomen, protuberant and distended abdomen, palpable spleen and hernia, were strikingly prevalent in pre-school age. They ranked as follows: Pre-school, 16.5 per cent; six to twelve, 2.1 per cent; and twelve to eighteen, 1.9 per cent of the children had defects. The reason for this was not far to seek. Such defects are largely the result of rickets in infancy, and they tend to disappear with age. The large number of abdominal defects is of interest, we believe, because it indicated a fairly large percentage of chronic intestinal disorders and poor musculature, a combination to be expected in a group which contains a large number of rachitic children.

Orthopedic Defects—The number of children found with these defects we believe to be almost unprecedented. While the percentage of children suffering from such defects rarely exceeds 2 or 3 per cent we found that in the children of pre-school age, one-fourth (24.6 per cent) had orthopedic defects. In the next group the percentage falls off to 7.9 per cent, and in the oldest group to 5.5 per cent. The following table shows in detail the number of orthopedic defects in each group:

	1 to 6		6 to 12		12 to 18	
	No.	PC.	No.	PC.	No.	PC.
Defects of Thorax...	119	37.3	43	41.	3	23.
Defects of Extremities.	178	55.7	33	23.7	1	7.6
Kyphosis of Spine....	9	2.8	8	7.6	1	7.6
Curvature of Spine..	2	.6	8	7.6	3	23.
Inversion of Feet.....	4	1.2	9	8.6	1	7.6
Pes Planus	3	9.4	1	.9	4	30.7
Polio deformities	2	.6	1	.9	0	0
Torticollis	2	.6	1	.9	0	0
Total Defects	319	100.	104	100.	13	100.

The most striking feature of the variation in orthopedic defects with age was that while in the pre-school group defects of the extremities led, in the older groups, defects of the thorax led, and there was also a marked increase in the proportion of defects of the spine. In other words, the children apparently grew out of the defects of "bow legs" and "knock knees", but retained many of the defects of the chest and spine. The latter defects naturally have a more deleterious effect upon the child's physique than those of the extremities. Again it is to be noted that practically all of the defects had their origin in rickets.

Skin Conditions—Defects of the skin were practically confined to pediculosis, ova and dirty scalp, with a few cases of impetigo. There was little variation in the number of such defects in the different age groups except that in the pre-school group there were more cases of impetigo.

DEGREES OF MAL-NUTRITION

After defects of the nose and throat and teeth, defective nutrition ranked highest in the number of defects found. The Dunfermline Scale of grading nutrition was used. Between the first two groups there was no significant variation in the defects found, for in the pre-school group 37.9 per cent of the children had defective nutrition Grades iii and iv), while in the group from six to twelve 38.4 per cent had defective nutrition, a variation of about a half of one per cent. In the oldest group, the percentage fell off to 32.2 per cent.

In determining defective nutrition, all of the symptoms were considered, weight for height, general musculature, the presence of subcutaneous fat and the redness of the mucous membranes. The value of the diagnosis was enhanced by the fact that all the examinations were of stripped children.

The results of these examinations among the children of pre-school age may be summed up as follows: The highest peaks of the incidence of defects were found in those of

(1) nose and throat, (2) nutrition, (3) teeth, (4) orthopedic, (5) glands, and (6) abdomen. The defects among the children of preschool age exceeded those of the older children in the orthopedic, abdominal and head defects. All of these defects were largely the result of rickets. Rickets, on the other hand, had its highest incidence in the period of infancy from six to eighteen months. The principle that there is no sharp cleavage physiologically in the various ages of childhood is thus strikingly demonstrated. To correct many of the defects peculiar to the children of preschool age, careful supervision of the period of infancy is essential. It was the recognition of this principle which led the Association to inaugurate a service for the care of child life extending in an unbroken chain from the pre-natal state through adolescence.

CORRECTING DEFECTS

The clearing up of nose and throat defects, particularly defective tonsils and adenoids, is by all means our most difficult task. About twenty cases a month (of all ages) are found which require removal. The first step is to get the parents to consent to the operation. This is not an easy task. It is hard to convince the parent that such an operation is desirable and that it is attended with no great risk. The reply of one mother is fairly typical of the opposition which we find. When approached on the question of a tonsil operation she refused to give her consent with the remark: "I prefer to let my child die from natural causes." Repeated visits and the gradual winning of the confidence, even the affection of the mother, are necessary to gain her consent. Once the consent is gained, the next obstacle is in finding a hospital which will perform the operation. We have now about ninety cases waiting for operation. An average period of nine weeks elapses between the giving of the consent and the actual operation. The unfortunate part of this lack of facilities is not that it impedes the work of the nurse, obliging her to keep the case open longer than would otherwise be necessary, but the effect upon the parents is even more serious. After waiting two months for the operation, the moth-

Chief Aim of the Study

It must not be inferred that the purpose of these examinations was to make a statistical study of the defects of childhood. Their real purpose was to furnish a guide for the nurse in dealing with the health of the family. The statistic array of defects found was only a by-product of one step in a very concrete health service for the district. A brief survey of what is now being done about the various defects is therefore most essential.

er often loses interest and withdraws her consent. Obviously, it is more difficult to gain the consent the second time.

The relation of the examining physician to the nutrition work is of vital importance. All children requiring attention (nutritional grades iii and iv are referred to the nurses for the removal of all defects which may be the cause of the child's impaired nutrition, and to the dietitian for nutritional care. The use of nutrition classes, either in the school or at the Community House, accompanied by visits to the home, has been the procedure with children of school age. With the children of pre-school age, nutrition classes are obviously impracticable. Since we can not expect the mothers to bring their children to us, we must go to them. All of the work with the pre-school child is done in the home.

The problem of weighing the pre-school child weekly in the home at first presented an obstacle. We have got round this by providing our workers with a portable scale which they take with them on their weekly visits to the family. The weekly weighing in the presence of the mothers enables us to drive home the need of proper diet, fresh air, exercise and rest. Seeing is believing. When the mother actually sees her child gain when the

"Has the Baby Gained?"

nutrition worker's suggestions are followed and lose when they are ignored, she is much more likely to see that instructions are faithfully carried out.

PREVENTIVE MEASURES

Children who fail to make the expected gain for a period of from three to six months are brought back to the examining physician for re-examination to determine if possible what is retarding the child. If some medical problem is involved, directions are given as to the proper course of treatment. The physician thus keeps in touch with all the children who need his attention without having to see the great number who respond merely to nutritional care and practical health education.

The work with the undernourished children of school age is carried out in cooperation with the school. The principals and teachers are themselves assuming more and more of the responsibility for the nutrition work. We are gradually, therefore, centering all of our nutrition work on the pre-school child. While we believe that there is great need for practical instruction in food and health habits among school children, we are convinced that preventive work can best be done with the pre-school child. It is essential, we believe, to get the child before his habit becomes fixed and before retardation has had its worst effects.

While our dental work is carried on in the schools in cooperation with the health department and the school authorities, provision is made usually on Saturdays and during the summer for pre-school children. We hope to be able to clear up the worst teeth of pre-school children through this arrangement. The nurses instruct the younger children in the care of the mouth and supply them with tooth brushes either free or at a moderate cost.

There is little that can be done for the orthopedic defects which we discover. When the doctor recommends it, however, children are taken to the orthopedic hospitals for operation or treatment. Plans are also being made for giving attention to bad postural conditions (many of which are the result of orthopedic defects), through gymnasium work and corrective exercises.

Congenital or chronic valvular heart defects of a serious nature are referred to the cardiac class at Bellevue. The doctor indicates to the nurse what instructions are to be given to the parents in caring for all heart cases.

Defects of ears, eyes, nose and skin are handled by the nurse in the usual manner. Serious cases are taken to clinics and dispensaries for treatment and advice.

AN ALL-AROUND SERVICE

The pre-school child has been slighted in health work because his environment is almost exclusively the home. He has fallen down, therefore, between the service provided for infants at the baby health

stations and the school medical service provided for school children. The community health service of the Association for Improving the condition of the Poor, we believe, is solving this problem for its own area by carrying an expert medical, nursing, nutritional and dental service to the homes of the people of the area, and by coordinating this health service with the civic and recreational organization of the Mulberry Community House. It is in the further development of both approaches to the problem, the expert health service and the community organization, and by the further integration of them, that we hope to make a permanent contribution to the health of the child of pre-school age.

Babies' Hospital of Philadelphia Dedicates Its New City Building *

THE new city building of the Babies' Hospital of Philadelphia was dedicated May 9, 1921. Visitors were taken over the building, and then the formal exercises were opened by Dr. Charles A. Fife, the president,. Doctor Fife said:

"The functions of this building can not be clearly understood unless considered in connection with the purport of other units of the Babies' Hospital Group. The following brief review of the stages through which the system has evolved is intended to show the relation of one department to another.

"The Babies' Hospital was founded in 1911 as a country, open-air, summer hospital by a group of physicians who realized the inadequacy of existing facilities for the care of very sick babies. Though approximately three-fourths of the children who died in Philadelphia were babies, only about one-fifth of the children's beds in hospitals were available for infants. The experience of these physicians had taught them that during the hot weather infants do not thrive satisfactorily in the crowded mid-city hospitals in which the treatment of babies is only one phase of their activities. These physicians were convinced of the need of establishing a hospital in the country devoted solely to the care of sick children in the most perilous period of their lives—babyhood.

"The Children's Hospital of Philadelphia generously loaned the new institution its unoccupied country property at Wynnefield. Here the hospital was successfully conducted for four years until the gift of a site farther in the country, and on higher ground, permitted the hospital to be moved to its own quarters at Llanerch, Delaware county, Pennsylvania.

"The Summer Hospital consists chiefly of four portable, open

*The Managers have generously given these excerpts from the papers read. It is hoped that the papers in full will be published by the hospital.

houses, each divided by muslin partitions into five cubicles large enough for two babies. A force of attendants (one for every three babies) ample to permit 'mothering' the little patients as well as careful nursing, has always been maintained. This has been considered an all-important policy of the institution. Aseptic nursing has always prevailed. Before a nurse touches a baby she carefully washes her hands, and dons one of the gowns assigned to the nurse of each baby. Individual toilet articles, thermometers, lubricants and destructible single service diapers, have always been used.

"At present only babies suffering from acute gastro-enteric disorders are admitted to the Country Hospital. The results of treatment have been most gratifying, the mortality being very much lower than in the same type of cases in mid-city hospitals under equally good medical attendance.

"Lack of funds has prevented the Managers from maintaining the Country Hospital Ward Service during the winter months, except for two seasons. But the experience of these two winters convinced the Staff and Board that babies who must be confined to hospital beds for more than a few days, do best in country or sea-shore institutions, providing the medical and nursing attendance is efficient. Therefore, the Board of Managers of the Babies' Hospital earnestly aspires to develop in the Country Hospital a continuous bed service of sufficient extent to care not only for the babies referred from its own Outpatient Department, but from many receiving stations in other Health Centers. Perhaps this dream of a big central country hospital, with many receiving stations throughout the city, may soon be realized through the co-operation of the City Health Department and the Children's Clinics of other hospitals. From the first the Babies' Hospital has endeavored to coordinate its work with that of other institutions. In fact, the majority of its Summer Hospital patients are received from other hospitals and welfare associations.

CONVALESCENT CARE

"The original plan of the Babies' Hospital did not extend beyond the provision of the best possible facilities during the summer, but the number of re-admissions of patients the first season convinced the Board of Managers that the period of treatment must be lengthened in order to guard against relapse, and that the "follow-up" methods in the homes of discharged patients must be extended. Therefore, since the first year, a convalescent home has been in operation in which the babies usually stay about three weeks after their discharge from the hospital. Also, the force of visiting nurses has been increased in proportion to the need.

"The convalescent section has been separate and distinct from the wards for the acute cases. For a number of years the Presbyterian

Hospital of Philadelphia magnanimously assigned a ward of its delightfully cool Richardson Home, at Devon, to the convalescents from the Babies' Hospital. The two hospitals cooperated in the equipment and maintenance of this ward, but a very considerable portion of this expense was borne by the Presbyterian Hospital. Later on, a generous gift from one of the Board of Managers of the Babies' Hospital provided a Convalescent Ward at Llanerch.

"Two years ago a seashore house was opened at Beach Haven, New Jersey, for convalescent babies who require greater reserve strength than can be obtained in the country, and also as a preventive agent for patients of former years. One of the chief features of the seashore work is the provision of instruction to the mothers who accompany their children. The house at Beach Haven was presented to the hospital as a memorial to Ethel Burnham Worcester, whose love of children and desire to see a home for babies established here inspired this lovely gift.

"Since the first year efficient visiting nurses go to the homes of all the patients before they are discharged, if possible, and always immediately after their discharge, from the Summer Hospital. In the homes the nurses begin their follow-up work, with the family as a unit, in the hope of making each home a better place for the baby. Visits are made as frequently as indicated —never less than once a month until the patient reaches the age of six years.

"This visiting nurse and medical social service work soon demonstrated the need of a mid-city station to which the nurses could refer any of their charges for desired medical advice. In 1913, therefore, an Out-Patient Clinic in conjunction with a Receiving Station for the Summer Hospital, was established on Lombard street. This dispensary was soon expanded into a Health Center.

A HEALTH CENTER

"Pre-natal clinics, health clinics and instruction classes were established in the small dispensary building. The Medical Social Service was extended to all Dispensary as well as to the Country Hospital patients until at present nine visiting nurses are employed. The Managers have realized, from the first, that a hospital must do more than relieve suffering and cure disease; it must have place in the prevention of disease, which is the higher sphere of medical science.

"Last year the hospital undertook intensive work in the Fifth Ward—thus becoming a Community Center in the ward in which it is located.

"Space was required for the enlarged clinics, and the instruction of mothers, fathers and older sisters. More room was needed for medical social service. Research as to causation of stunted development, and of disease, must be done, and this work required space. Our

Preventive Department and Dispensary had outgrown its quarters three times, and had always been handicapped by the lack of facilities.

"A splendid gift in memory of Edwin D. Douglas encouraged the Managers to go forward with the building which we are here to dedicate.

TO PREVENT DISEASE

"In going about the hospital please bear in mind that the prime function of this new building is to provide facilities for the prevention of disease. It is the business of this 'Health Center' or 'Out-Patient Department' (no one term that fully describes its functions has yet been suggested) to keep its clientele well, and to keep mother and baby together at home. It is also its business to see to it that the home is in a sufficiently hygienic state to admit of proper nursing, in case the baby should become ill. The cribs in the 'cubicle floor' are intended for patients who are brought to the Out-Patient Clinics in such condition that it is deemed inadvisable to attempt to treat them in their homes. After a few days of hospital care it may be possible to continue treatment at home. If prolonged hospital treatment is needed, as may frequently be the case, the patients are to be transferred to the Country Hospital, or to other institutions. The beds are also intended for patients requiring special study, or special laboratory examinations."

Presentation of Building

In presenting the building, Mr. Fred A. Rakestraw, Chairman of the Building Committee, spoke of the cost, which was in round figures close to a quarter of a million dollars. Mr. Rakestraw said: "The ground cost $40,000; building, about $180,000; equipment and supplies, $27,000. In cost it represents in its conception, development and completion an incalculable amount of thought and work which was freely given by those interested in enlarging the Babies' Hospital, and it is a pleasure and privilege to me to pay a tribute to all the workers who by their earnest, constant and unselfish efforts, singly and in cooperation with each other, have planned and directed the affairs of the Babies' Hospital to this happy event in its career of usefulness.

"As to its value, we cannot name a dollar valuation, for who can value in dollars the human lives that this institution has saved and undoubtedly will save.

"To those who have been carrying on the work of this institution, this building is the realization of an ambition and an ideal. The money for the ground was raised by private subscription by the Board of Managers and Social Service Committee, and the balance needed was raised later by a 'drive' in which we were aided by a large number of friends. These funds, together with the gift from Mrs. Edwin D. Douglas, have enabled us to pay for this building, so that today the property is free of debt."

Acceptance of Building

In accepting the building, Mr. Howard A. Loeb, the Vice-President of the Board of Managers, said in part:

"I am very happy indeed to be asked to accept on behalf of the Babies' Hospital of Philadelphia this magnificent building, representing, as it does, not only the result of the careful studies and experiences of physicians, architect and builders, but also the interest and generosity of our very large circle of friends. To all of them we owe a large measure of gratitude, for they have made it possible for us to translate the aspirations and ambitions of the past into the splendid reality of the present."

Mr. Loeb made a special plea for an endowment fund for operating the research laboratories. Mr. Loeb said: "We have the laboratories and the equipment. We now need the best talent procurable, and it is only the best that is of value in carrying on the work. To attract such talent means the payment of adequate salaries. I know of no greater monument to one's name, no greater contribution to the welfare of this city and its infants than the endowment of these laboratories, or the creation of funds for specific branches of investigation. May these potential facilities stimulate us to convert them into active agencies for the study of baby welfare."

Mr. Loeb closed his speech with a special tribute to the work and enthusiasm of Miss Rena P. Fox, the superintendent of the hospital.

Health Department Cooperates

Dr. C. Lincoln Furbush, as Director of Public Health and Charities, in Philadelphia, pledged the hearty support of the Health Department to the hospital. Said Doctor Furbush:

"One of the most progressive programs in the conservation of the lives of babies and the promotion of health among the infant population of this City is to be carried into effect by the Babies' Hospital of Philadelphia.

"The past work of the Babies' Hospital has been crowned with unusual success for the reason that your Board of Managers and Staff have been constantly interested in the work, at times at great personal sacrifice—and your efforts have been continuously progressive.

"I understand that the work of the Hospital Staff will be especially directed toward the prevention of disease among infants and the improvement of measures that favor a healthy development by bringing about improved sanitary conditions in the home, also the scientific supervision of diet and physical needs.

"The Department of Public Health is particularly interested in the conduct of your clinic and the educational features which you propose to introduce into this service. The class in nutrition, which you have recently established, is conducted along scientific as well as practical lines, and your effort to hold to high standards of methods of instruction will, I am sure, bring

far-reaching and positive results.

"The public health nurses and the medical social service workers connected with the Babies' Hospital should in the course of their field work become familiar with the methods of routine sanitary inspection, and have knowledge of existing sanitary laws, rules, and regulations of both the State and City Departments of Public Health, so as to be able to detect the non-observance of existing laws; to observe insanitary conditions in the home; and to report their findings in a concise, direct and intelligent manner to the Health Department for action.

"Careful records should be kept of these inspections, and re-inspection should be made in order to ascertain that the nuisances complained of have been properly abated.

"The field staff also will aid our Department by promptly reporting contagious diseases and taking the necessary steps to safeguard others living in the same dwelling. In other words, we should like to look upon your field staff as an auxiliary force cooperating with the Department of Public Health.

"The Department welcomes every agency whose field of activity is to promote progressive preventive medicine based upon scientific foundations rather than upon popular standards. You have an institution that stands for the very best, and it will be our great pleasure, as a Department, to cooperate in every way possible toward carrying out your prospective program."

The Hospital's Educational Value*

Dr. Henry Larned Keith Shaw gave a resume of the history of children's hospitals from the first foundling asylum in 787. The first hospital in America devoted solely to children was opened in 1855 in Philadelphia. Doctor Shaw said:

"The Babies' Hospital in New York was an offshoot of the babies' ward in the Post Graduate Hospital, and was incorporated as a separate institution in June, 1887, with Doctors Julia and Sarah McNutt in charge. They resigned in 1889, when the hospital was located on East 36th street, with a capacity of eight beds, and Dr. L. Emmett Holt was appointed attending physician. No one can estimate the effect these hospitals have exerted on the medical thought of this country, or how far-reaching have been their influence in the reduction of infant mortality and morbidity, and in the scientific study and treatment of the disorders peculiar to infants and young children."

In discussing the relation of the hospital to pediatrics, Doctor Shaw quoted Doctor Holt as saying that "no single agency for the reduction of infant mortality can do as much as that which educates the medical profession through which the public is ultimately reached."

Of the out-patient department or

*This paper will appear in full in the Archives of Pediatrics.

dispensary Doctor Shaw says it "is more than an adjunct of a hospital —it is an integral part. Originally the term dispensary was used to denote a place where drugs were dispensed on a physician's prescription. Nowadays, this is but a minor function, and patients are brought for examination, diagnosis, advice and treatment. In a babies' hospital many cases after the diagnosis is made in the wards and a proper treatment instituted, can be returned home, and brought at greater or less intervals to the dispensary for examination and observation. The social service worker and the visiting nurse can then check up conditions in the home.

PREVENTIVE WORK

"Doctor Fife in his interesting report outlines the work you are undertaking along the lines of preventive medicine. This institution can render no greater service to this community than to prevent diseases and keep the babies well. Herein lies the solution of the problem of infant mortality. The prophylactic or child hygiene clinic is a preventive clinic, and should be held at a different hour, and only healthy, well babies received. If they become sick, they are at once transferred to the clinic for sick babies. Systematic physical examinations, periodic weighing and intelligent supervision should be accorded each infant. The mothers are encouraged to keep their babies well and properly fed, and are instructed in the elementary principles of baby hygiene. Visits to the homes are made by the social workers and nurses who advise and assist the mother in her own surroundings, with her own equipment. A visiting dietitian to demonstrate in the homes the cooking of simple and inexpensive recipes has proven of immense value in some of these clinics.

"Doctor Fife struck the keynote of successful charitable undertakings when he urged a closer cooperation with other agencies engaged on this work. Elimination of duplication, and overlapping and wasting of efforts can be made possible only through cooperation and coordination. With it, you will become a powerful influence in saving the babies and promoting the health of the future citizen and his mother."

A Health Demonstration

The evening session was devoted to a consideration of the relation of a Babies' Hospital to the various child welfare problems.

Dr. Samuel McClintock Hamill, of Philadelphia, read a paper on the possibilities of a health community center as a health demonstration. As to the importance of health, Doctor Hamill said:

"The great mass of the public, the educated as well as the uneducated, fail to fully understand the value of health, their responsibility in attaining it, and their right to demand it. There is, in short, a very decided lack of interest in human health.

"We rightly and willingly pay heavy taxes and expend vast sums for the education of our children; and yet what is education without health? What does it profit a child to be educated, if he has not the physical stamina to put his education to some useful purpose? And how many thousands of children fail every year to develop intellectually because they are physically unfit, and physically unfit because we have failed to demand that their physical development be given an equal chance with their intellectual growth?

"It is a bit hard to understand why we have so persistently undervalued health. Certainly health propaganda has been widely distributed, and yet there seems to be no concerted public demand for larger appropriations for the protection of the public health, nor any widespread interest in the methods of health procedure, that are followed by our municipal, State and Federal Governments.

"There are some enlightened health officers and quite a number of interested citizens who are seeking better things, but every attempt that is made to install new and essential methods of procedure, or to build up existing methods, is met with the cry, 'It costs too much!'

"Health is fundamental to all progress; therefore health must be maintained no matter what the cost. This is the lesson we must learn, and this is the demand the public must make of its legislators.

"Notwithstanding the public apathy, great reductions have been made in the infant, and, indeed, the general death rate. It would be impossible to enumerate all the procedures that have led to this result. The control of epidemic diseases by improvement in milk and water supplies, the cure of diphtheria by antitoxin, vaccination against smallpox and typhoid fever, and the better municipal control of the contagious and infectious diseases, have been powerful factors.

"Splendid assistance has also been given, largely by volunteer agencies, in the education of the public in better methods of caring for the health of the family, especially through the direct teaching of the people in their homes.

"In spite of all that has been accomplished, however, recent events have emphasized the fact that there is still a vast deal of preventable, handicapping sickness to be overcome.

IGNORANCE OF HEALTH CONDITIONS

"The necessity of saving our children, because of the threatened destruction of adult life in the war, led to more careful study of the health of the child. Here again the results surprised us. We found that very serious undernourishment and physical defects, such as enlarged and infected tonsils and adenoids and decayed and infected teeth, which are much more of a menace than is generally recognized, are so common in our schoo

children as to be almost universal.

"The results of these intensive studies revealed our ignorance of health conditions with which we had lived in intimate contact for years. Is it not possible that we are still surrounded by many menacing conditions that we utterly fail to see?

"I believe it will be possible for you to develop a demonstration of community health supervision such as has never been made, and which will serve its purpose not alone in Philadelphia, but in the country at large. But above all else, such a demonstration would reveal to the people the fact that disease is in large part unnecessary, show them the methods of preventing it, and point out to them their responsibility in securing health for themselves, their children, and the community.

"If health protection is ever to be secured, the public conscience must be awakened to its importance, and the people trained to demand it, just as we now demand the highest measure of efficiency in the education of our children.

"If we can once train not the few, but the masses to understand the meaning, the value and the joy of health, and show them that the great majority of diseases can be prevented, there will be no difficulty in establishing this necessary demand.

"We need faith in our cause, perfect organization, courage and indomitable perseverance, to win in this or any other fight. And if we have these fundamental qualifications, the fight can be won."

A Pilgrimage of Humanity

The closing paper of the evening was read by Dr. John Foote, of Washington, whose address contained the following allegory:

"In olden times men made pilgrimages of many miles on foot to visit those hallowed spots where shrines had been raised to other men and women who by their noble lives or heroic deaths had given testimony to the faith that was in them. Sometimes these pilgrims traveled on the high road; sometimes they ventured into the depths of the forests; sometimes they forded rivers and climbed up mountain sides. And when they had reached the summit of the mountain, with weary bodies and bleeding feet, they would rest a little while and look back on the way which they had come, thankful that they had ventured so far in safety toward the goal of their adventure.

"We, too, are today taking part in a pilgrimage—a pilgrimage of humanity that has lasted a hundred thousand years, and in the dedication of this institution we have reached a pinnacle on the way to the millennium of Child Welfare that has never been attained before. We are presiding today not merely at the foundation of an Institution, but at the perpetuation of the idea that henceforth the Children's Hospital must be a place where prevention of disease is

taught as well as a place where disease is to be cured. And from this pinnacle it is but natural that, like the pilgrims of old, we should look back upon the way which we have come—the way which the human race has traveled, and gaze down upon the lesser mountains of attainment and the deep valleys of ignorance and failure that lie behind us.

"Religion, and war, and later, science, have played a part in the evolution and development of the hospital. But future generations will write of the foundation of this institution as a step in the social history of the child just as momentous and as pronounced as was the abandonment of child sacrifice or the foundation of the foundling asylum.

"We have here the crystallization of the idea that the health of the child and the welfare of the child depend more upon educational propaganda than upon curative measures—in a word, that child hygiene work is educational work. We have here in concrete form an expression of faith and confidence in the progressiveness and the intelligence of the human race, for this institution is more than the endowment of a building, it is the endowment of an idea, and from this pinnacle of the pilgrimage of humanity toward the millennium of social progress, we can well afford today to rest a little while, even though our souls may be weary with striving, and look back with thanksgiving o'er the way which we have come."

Pre-natal Care

On the afternoon of May 10th the meeting was under the auspices of the Social Service Committee, of which Mrs. Charles F. Jenkins is chairman. Among the papers read was one by Mrs. William Lowell Putnam, under whose leadership the Committee on Prenatal care of the Woman's Municipal League of Boston undertook the first organized work in this country for expectant mothers. In speaking on prenatal care Mrs. Putnam said, in part:

"You remember that 'Alice' when she was in 'Wonderland', asked in one of her quandaries, where she should begin, and was told to begin at the beginning and keep straight on till she got to the end. This was very sound advice, because if we do not start right, it is almost impossible ever to get wholly right again—whereas if the start is right, things are uncommonly apt to run easily along the same lines. This is just as true in the starting of new lives as it is in everything else.

"Much that is called prenatal care starts with the last two months of pregnancy, but such care to be thoroughly satisfactory should begin as early in the pregnancy as possible.

"During the first few months of pregnancy, the child is either well formed or malformed, and if the latter, the defects are likely to be irremediable, hence this early period of pregnancy is necessarily the most important period of life.

What can be done about it? How can we prevent things going wrong? Only by making it easier for them to go right than to go wrong. In medicine this is all that can ever be done. The expectant mother must be carefully guarded medically.

TEACH THE FATHER

"Another thing, quite as important as teaching the mother, is to teach the father also. One of the greatest mistakes made from the beginning has been the assumption that the mother is the only person who really cares for her child—the father is assumed to take no interest, and to feel no real affection during the child's early years. This is an excellent way to make a man's affection less, for most of us are influenced by what we find is expected of us, and if nothing is expected, little will be done by the ordinary father for his little child, and that great means of developing love, the sacrifice of self to help the object of our sacrifice, is lost. Among the foreigners, the man is more truly the head of the house than among our native stock—and if the father says 'no', to any plan concerning his child, the 'noes have it' indeed, but even among native Americans, the mother alone can never do what can be accomplished if both parents work together. Never will the efforts for Child Welfare accomplish what they might until the father's interest is enlisted—until he feels his responsibility to his child—from the moment of conception, and earlier still—until his natural affection is encouraged to develop into that love which only a father can feel, and which Holy Writ uses as the symbol of divine love.

"The educational side of prenatal work must teach the parents the rational way for the mother to live. It is not necessary that the father should follow the same rules, although a patient once told one of our nurses that her husband had adopted the diet prescribed for her and thought he felt much better for it! The father must, however, understand and be appealed to for interest and help at all times.

MEDICAL SUPERVISION

Beside education in right living, the mother must be watched by the doctor or nurse for signs of possible evil, and at the least appearance of trouble, the doctor must be consulted, for many a serious illness can be prevented at its beginning. The patient, however well, must be seen by the nurse every ten days —not on a ten-day average, but at intervals not longer than ten days —and should any bad symptons appear she should be visited as much oftener as may be necessary. This routine, which was evolved through many years of experience by the Prenatal Committee of the Woman's Municipal League has reduced the infant deaths among those cared for by one-third to one-half as compared with cases not having this care. It has cut still-births similarly almost in two. It has reduced the premature births

to seven-tenths of one per cent (.7 per cent) and the cases of threatened eclampsia from 10.2 per cent, to less than 1 per cent, and its cost was found to be under $3.00 a case.

"Of course, it costs more now, because everything has gone up so in price, the nurse's salary, the carfares and everything else that may be needed."

Post-Natal Care

Dr. Lida Stewart-Cogill, of Philadelphia, said:

"Next in importance to pre-natal care is the *post-natal* care of the mother. We who are interested in maternal and infant welfare work realize the statistics concerning the morbidity and mortality among mothers and infants are too startling to be overlooked.

We are told over and over again that 50 per cent of these deaths are preventable, and we agree with John Galsworthy: "What right have we to call ourselves civilized, when we permit such neglect of mothers and babies."

The following are a few ways by which mothers may be kept in the best physical condition:

Increased propaganda on importance of *pre-natal care.*

Skilled attendance during labor.

Proper post-natal care of mother (a) during puerperium; (b) during entire child-bearing period.

Greater amount of instruction in medical colleges on pre-natal and post-natal care of the mother.

Students must leave college impressed with the fact that obstetrics is one of the most important courses in the curriculum, that the future of our nation depends upon the kind of children coming into the world, and healthy babies mean healthy mothers.

The duties toward the mother are barely begun when the child is born, too many are neglected during the puerperium and later, too many never have an internal examination at the end of the puerperium, and too many are left uninstructed upon the care of themselves. Long existing displacements of the uterus can be overcome by proper care and treatment during those first weeks following childbirth. Furthermore, we also know such conditions will develop and continue to exist with all their many accompanying ills if proper oversight is not given.

My plea is, that we establish Health Clinics for mothers so they may be under observation through the entire so-called child-bearing period. Our aim to be:

First: To restore the mother to perfect physical condition after birth of the child.

Second: To keep her in such condition by having her under observation during the whole child-bearing age.

By having her report every three or four months to this Health Clinic for a full physical examination and laboratory tests, and having her referred to proper clinic for treatment, then and then only it seems to me will we begin to find an improvement in maternal statistics.

Pre-natal care has done wonders

to make labor safer for mother and child. Post-natal care will do much to keep mother and child well.

Let us not neglect the father; he must be educated along these lines, that he may be able to do his part intelligently.

Next year may the celebration of Mother's Day mean not only what mothers have done for *us,* but what we have been able to *do* for mothers.

The Hospital as a Service Center

Dr. Philip Van Ingen of New York City then outlined the Social Service work of a babies' hospital saying that "the hospital should be a service center, not the repair shop alone of the health movement." He urged this hospital to provide certain things which most infant's hospitals do not have.

"First of all," Dr. Van Ingen said, "in the hospital no baby should be admitted until his complete social history has been obtained, and no baby should be discharged until his home conditions have been personally investigated by the Social Service. He should be visited within forty-eight hours after he returns home.

"In every ward there should be ward helpers, attendants — call them what you will, whose duty it should be to feed the babies. Pick them up and feed them. In my practice one of the things which I insist on for every baby over six months of age, who is not seriously ill, is one quarter to one half hour of freedom and activity. Freedom from his restraining bed and body clothes. He lies in the sun, or wherever it is warm, and he is encouraged to kick and crow and smile. That may sound absurd, but I venture to predict that you will find it is worth while. That is the duty of the Ward Helper.

"In the Dispensary enlist your corps of Volunteers. Dispensary service is a bugbear to many doctors because they have to spend so much time in clerical work. In Bellevue Hospital dispensary* in New York, we admit we cannot run our clinic without our volunteers. We have about forty of them. They take all our histories, weigh and measure the patients, take temperatures, and explain many details to the parents. They not only make dispensary service interesting to physicians, but very interesting to themselves. It saves an enormous amount of time for the patients, and we can handle about three times as many in an hour. Your social service should have that as one of its functions.

THE DISPENSARY'S IMPORTANCE

"The Dispensary has been in the past, and often still is—the step child of the hospital. Those with broad vision see in it the center of the whole system — the most important phase of the hospital work. Only those babies seriously ill or needing special investigation or treatment should be admitted to the wards.

"The Dispensary should have as part of its Social Service, its Home Care Department, which should include both educational

*See page 273, in this issue.

and sick nursing service. In every hospital every year there are hundreds of cases which did not really require ward care, if they could have been watched in their homes. The feeding cases—after the acute stages have passed—belong to this class. In summer time our baby wards are crowded with such cases. A nurse can watch and give treatment to from at least six to ten such cases a day in their homes. What does it cost to care for them in the wards? Three-four-five dollars a day. Is it wise economy to make them ward patients, after they no longer need it, but are better at home?

"The Dispensary Home service should also have its visiting physician staff, to visit such cases as are too sick to be brought to the Dispensary.

"Perhaps all this is not Hospital Social Service. Very well, then, don't have Social Service. Call it some other name—Efficiency Service—Philadelphia Baby Hospital Service.

"I hope you will show that Philadelphia believes the function of a Babies' Hospital is to do 100 per cent efficient work for all those with whom it comes in contact. I make a plea on behalf of the baby for the restoration and maintenance of his health through the elimination of extravagant economy —for a Social Service which **will** have a better appreciation of his personality—a better appreciation of his occupations, habits and environmental conditions, both in and out of hospital."

The New Building

"The Hospital is approximately forty by eighty-one feet and consists of a basement, six floors. and a roof garden. It is of reenforced concrete construction with cement floors erected at a cost of about $150,000. It is so placed as to get the avantage of the summer breezes and the winter sun. The basement contains a waiting room, which is equipped with a stove, so that it may be used as a demonstration room. Here, at present, The Child Federation holds its Nutrition Clinics. There are two special treatment rooms opening from this room. On a separate hallway are four small isolation rooms (each with an exit to the street) in which cases suspected of contagion may be held until diagnosed. On this floor is a small closet for drugs. A Mortuary, and the boiler room complete this floor. There will be installed here provision for the fumigation of mattresses.

"The first floor is given over entirely to clinics — prophylactic, medical, pre-natal, eye, ear, nose, throat and dental. There are two large waiting rooms, one of which is divided by white enameled steel partitions into compartments large enough to hold a mother and three small children.

(Note—Dr. John Diven, who has had most to do with planning and equipping the building, is preparing a full description of it to appear soon in *The Modern Hospital.*)

"These waiting compartments, which it is believed lessen the danger of cross infection, are numbered. The patients are assigned to them by the admission clerk, a trained nurse who is stationed in a booth just within the main entrance of the building. She has charge of all the Dispensary records and makes out all admission cards. All medical social service nurses are in attendance in the dispensary to receive instructions from the doctors. Each baby is weighed and prepared for examination in its own waiting compartment. Nine examination and treatment rooms open off the waiting room.

"On the second floor are the administrative offices of the Medical Director, Superintendent and Financial Secretary; the record room, the medical social service workers' office and consultation room. One end of this floor is used as a staff room and library, and it is large enough for committee meetings.

The Babies' Hospital, Seventh and De Lancey Streets

"The third floor is unassigned. Its construction increased the cost of the building very slightly, but will for years forestall expensive additions necessary to meet future development. The Babies' Hospital means to keep abreast of the progress of Medical and Social Science.

"On the fourth floor are well-equipped laboratories for routine work and for research. The most cherished hope of the Managers and Staff of the Babies' Hospital is that from the laboratories may come life saving and health promoting discoveries. The quarters for internes are on this floor.

"The fifth floor is given over entirely to nurses' quarters, a separate room being provided for each nurse.

"The sixth floor is the hospital floor. Eight 'cubicles' with glass partitions make it possible for the floor nurse to see into any portion of these rooms at any time. The ninth cubicle is equipped for a mother and child, if for any reason it should be found desirable to keep them together, or for a special nurse and child. Each cubicle opens into a porch, also divided from the neighboring porch by means of a glass partition.

"Each baby has an entire individual equipment. A small metal cabinet attached to the top of each radiator holds a twenty-four hour supply of body linen. Single-service diapers (made of paper, gauze and cotton) are used for all babies and each cubicle has a small, tightly covered bucket in which the soiled diapers are kept until burned in the incinerator, which is in the utility room on the same floor.

"In each room there is a bath slab, with spray bath attachment. The faucets of this bath are so arranged that the nurse may wash her hands there before leaving the room. Separate gowns are worn in each cubicle.

"Not only is the equipment individual, but every effort is made to give individual care—enlightened mother care—to each baby. He is picked up frequently and is held while being fed.

"The milk preparation room is completely equipped for taking care of about one hundred babies. This was done with the idea that it might be found desirable or advisable to prepare feedings for non-resident children. A small operating room is ready for emergency surgery of any kind.

"The roof garden is another of the unique features of the building. Here it is planned to afford to mothers and babies a refuge from the extreme heat of the city streets. Large sand boxes, toys, "kiddie-cars", swings, and so forth, will keep the toddlers amused while mothers rest for awhile in comfortable lounging chairs. Small hammock beds have been provided for the babies. Two small rooms are fitted up with toilet facilities for convenience in washing and changing the children. An attendant will be present to guard against mishaps of any kind."

Health Education

The Advisory Committee of the National Child Health Council on the Health Education of School Children

ON May 12th sixteen persons, representing expert opinion of varying types in relation to the health education of the school child, met to form the Advisory Committee of the National Child Health Council on Health Education of School Children.

This committee has undertaken the difficult problem of reviewing the experience in health education of school children in order to present a consensus of authoritative opinion on what has been proven sound and those things that should be still further studied. The points of view of physicians, nurses, nutrition workers, general educators and specialists of other kinds, were represented by delegates from large professional groups as well as by individuals who could speak with authority.

The importance of health educational work as being carried on was emphasized by all. On the other hand, one suggestion made to the committee was that if the examination of children upon admission to schools became a general practice that would be a great step in advance. Another emphasized the importance of developing a plan of health supervision of pre-school children. The relationship of health education in the school to that in the homes was stressed as a most important matter to which inadequate attention had been given.

After an entire day of discussion it was the unanimous opinion of the committee that it should concentrate on three things. (1) it should endeavor in the light of experience and present knowledge to prepare a tentative and elastic outline of the subject matter that should be included in school curricula, in special lectures, in relation to the school, in special class work and in school health literature. (2) It should similarly prepare a tentative and elastic outline of the machinery necessary for school health education, with a plan for the correlation of the work of grade teachers, teachers of special health subjects, other health or recreational supervisors, physicians, nurses and so on. Such an outline should cover similiar problems with relation to continuation schools and the work of pre-school children and the relationship of health work in schools to that in the home.

(3) It should consider all of the various methods of education, including project methods, organizations of children, special classes, school lunches, graphic and dramatic devices and methods for measuring the effectiveness of health work.

Already there has been a considerable demand for such an outline as the committee hopes to prepare. Therefore, it is planned to proceed with its inquiries and reports as rapidly as is consistent with thoroughness and with the study of the best experience wherever it may be found. The following sub-committees were organized to study and report upon the subjects assigned to them:

Three sub-committees were formed as follows, Dr. L. Emmett Holt having been elected chairman of the whole committee:

1. To consider questions relating to the organization and administration of health education work and the preparation of teachers and others engaged in health work in the schools.

The members of this sub-committee are:

Dr. Thomas D. Wood, of Columbia University, New York, Chairman.
Dr. Willard S. Small, U. S. Bureau of Education.
Dr. William F. Snow, General Director, American Social Hygiene Association.
Mr. E. Dana Caulkins, representing the National Physical Education Service.
Dr. Ambrose L. Suhrie, School of Education, Cleveland, Ohio.
Dr. Randall J. Condon, Superintendent Public Schools, Cincinnati, Ohio.
Dr. Thomas E. Finnegan, Commissioner of Education, State of Pennsylvania.

2. To consider and make recommendations regarding the subject matter which should be included in health education courses for children of all ages.

The members of this sub-committee are:

Dr. Wm. H. Burnham, of Clark University, Worcester, Mass., Chairman.
Dr. Taliaferro Clark, U. S. Public Health Service.
Dr. Florence L. McKay, U. S. Children's Bureau.
Dr. H. H. Mitchell, representing the National Child Labor Committee.
Dr. Royal S. Haynes, representing the American Child Hygiene Association.
Dr. Dudley B. Reed, representing the American Physical Education Association.
Dr. Lewis M. Terman, Stanford University, Palo Alto, Cal.
Dr. Caroline Hedger, representing the McCormick Memorial Fund, Chicago, Illinois.
Dr. Harry B. Burns, Director, School of Hygiene, Pittsburgh Public Schools.

3. To consider and report on the best and most effective methods for conducting health education work.

The members of this sub-committee are:

Dr. James Mace Andress, Professor of Psychology, State Normal School, Worcester, Mass., Chairman.
Miss Maud Brown, Supervisor of Hygiene, Kansas City Public Schools.
Miss Katharine A. Pritchett, Director of Nutrition Division, Department of Public Instruction, Pennsylvania.
Prof. C. E. Turner, Institute of Technology, Cambridge, Mass., representing the Committee on School Health Program of the American Public Health Association.
Dr. A. W. Dunn, representing the Junior Red Cross, in the absence of Dr. E. George Payne.
Dr. Walter E. Fernald, representing the National Committee for Mental Hygiene.
Mr. C. Dinwiddie, National Child Health Council.
Miss Mabel Bragg, Asst. Superintendent of Schools, Newtonville, Mass.
Dr. F. M. McMurray, Professor of Elementary Education, Teachers' College, Columbia University, New York.
Dr. E. G. Gowans, Supervisor of Health Education of the State of Utah.
Mr. Clark Hetherington, Director of Physical Education of the State of California.
Mr. Charles M. DeForest, representing the National Tuberculosis Association.

Volunteers in a Children's Dispensary

Helen R. Sloan

Chief Volunteer Worker, Children's Medical Clinic, Bellevue Hospital.

IN December, 1916, when the world was at war and the shortage of nurses was beginning to be felt in this country, the first two volunteers came into the Children's Medical Clinic at Bellevue Hospital. Three months previous to this, the clinic had been put under the direction of Dr. Charles Hendee Smith, who has inspired his workers to bring it into its present state of efficiency.

At that time the Children's Clinic was being held in three rooms and divided into general medical, special cardiac and nutrition classes, and infants' feeding. The two new workers were placed under the direction of the Social Service Nurse, in the infants' feeding room. At first, they were on duty for three afternoons a week. Their duties were to weigh the babies, take temperatures, and help where needed. Before very long, these volunteers were promoted to taking histories, keeping a card index for the following up of cases, and to more advanced work.

At the end of ten months, the room was running smoothly. More volunteers had come in and their friends had provided additional equipment. There was also a decided increase in the number of patients, who began to feel the comfort of always finding a friend.

At the end of twelve months, the work had come to include the older children's room, as more volunteers gave regular time as their contribution to their country. No one who was there those first two years will ever forget the chaotic days, when, owing to the reduction of the medical force, only one doctor was at times present in the rapidly growing clinic. The volunteer hurried from screen to screen, pen in hand, taking down notes as the doctor made his examination, and remaining to explain his directions, while another worker followed the doctor to the next case.

PLAN OF ORGANIZATION

There are at present eight rooms in daily use by the Children's Medical Clinic. The staff consists of thirty-four doctors, of whom from twelve to twenty are present daily; a children's dentist; a head nurse in charge and a pupil nurse to assist in the Vaginitis and Luetic Clinics. On certain days in this department, there are also five Social Service Nurses, assigned to special classes for the home visiting and relief work. A paid secretary keeps the general files. The regular routine work of running the rooms is done by the twenty-one volunteers in this service—eight of whom attend daily.

There is one head volunteer worker who is held responsible by

the hospital authorities for all the other volunteers. All new workers, after registering in the Social Service Office, are interviewed and placed by her. If there are any suggestions or difficulties on either side, they are brought to her to settle. She works regularly in the clinic with the others. Applications for volunteers from all departments are made to her, and she is Chairman of the Volunteer Committee of the heads of departments. To coordinate these outside resources with the work of the hospital, she has been appointed a member of the Social Service Committee, and also of the Board of Managers of the Training School.

DUTIES AND OPPORTUNITIES

Almost every room is in charge of a volunteer, with one, two, or three under her where needed. Each worker is assigned to her own room on regular days and is not permitted to shift from clinic to clinic unless an emergency arises. By this method, she acquires a thorough training and becomes well acquainted with the patients—perhaps the most valuable part of the work. She weighs the children at every visit, takes temperatures, and fills out the history blanks of all new cases. Her name is written on the charts, and she takes the return notes on her own cases, whenever possible. This is of much benefit to the patients, and of great interest to the volunteer.

Being actually in the room with the doctors and patients, the volunteer hears the result of the examinations, and can then repeat and emphasize the doctors' directions. In hospitals where volunteer service is not a success, one generally finds that the volunteer takes the histories in an outer room and does not go in with the patient to see the doctor—her work ending with the recording of the patient's history. How could that method hold any worker for long? She gives her time—she must receive something in return. Let her see what the doctor does with the notes given in the history. Let her talk with the patient after the doctor's examination. Give her real human interest—that is more than enough pay.

Volunteers attend from one to five days a week. If they are obliged to be absent, they telephone, and they do not "come another day instead", unless they are particularly requested to do so. They are not permitted to send substitutes, unless they supply women who have already been trained in these clinics.

In the summer when the work is much lighter, it can be done by fewer people. Some of the volunteers who move out of town for the summer months, come in regularly once or twice a week and others take comparatively short holidays. Vacations vary in length from one to three months, and are so distributed that the work is not allowed to suffer.

There are many other duties and opportunities for the volunteer. Beyond a certain point, what she does

and what she gets out of it depends on the individual worker. She may select children for summer vacations, keep track of those who need tonsillectomy, see that the reluctant child is led by the hand to the dentist for perhaps many visits, persuade the frightened mother to leave her child in the hospital, or find and report cases of need to the Social Service Nurse, who may not be due in the clinic that day.

While taking the very complete history, there are many opportunities for an observant person to discover a serious home condition, and to give a great deal of much needed instruction in general hygiene and health habits, though, of course, no volunteer orders treatment, makes diagnoses or prescribes medicine. Volunteers have given material assistance to many patients, always, however, through the Social Service Nurses. For the last four years, every child who has come to the clinic on Christmas week has received a present and candy from the volunteers, this year the doctors also contributing.

FOUR LEADING QUESTIONS

The questions most frequently asked by visitors to the clinics are:

1. *Where do you get your volunteers?*
2. *What are your requirements?*
3. *Are volunteers regular in their attendance?*
4. *How do you keep them?*

The answer to the first question is that the greater number have come because of a friend already there, either another volunteer or a doctor; or through some member of the Social Service Committee, or the Board of Managers of the Training School. Other sources of supply have been the National League for Women's Service, during the war, and at present, the Red Cross, and Junior League.

As to the second question, the only requirements* are common sense and regular attendance. The need of both of these are thoroughly emphasized at the first interview.

As to the last two questions, they can be answered together. The volunteers attend regularly, because they are given responsibility, and know that if they are absent, the work will suffer. They stay, because volunteer workers will always be a success where they see that the doctors and nurses want and believe in them and expect the best. One of the original two is still in the clinic, and several of the others have long records.

The opportunities at Bellevue are unlimited for those with imagination and vision. With the whole east side crowding at the doors, what is already being done barely scratches the surface. This is only a feeble beginning of a work that can go much farther than we now can see.

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* Anyone who would like to take up this work in Bellevue Hospital, New York City, can apply at the Social Service Office daily between 1.30-4.00 P. M.

MOTHER AND CHILD
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JUNE, 1921

Skeletal Defects of the Child Before and After School Age

WHEN the wise physician, Soranus, came from Ephesus to Rome, in the time of the Emperor Trajan, he wrote in his aphorisms the statement that a greater proportion of city children have crooked limbs than children bred in the country. He was, of course, seeing rickets and describing it without naming it. Naming things is after all not nearly so important as describing them; it was an English novelist who said, "We cover up our ignorance with long Greek names." The ancients did not know the causes of rickets, but Soranus wrote down at least one valuable conclusion, even though he still subscribed to the view that deformities of the legs in children were caused by the curved position of the child in the uterus during gestation. It was because of this belief that he still maintained that all new-born babies should be swaddled until they were six months old.

The only rational way to get at knowledge is to observe carefully, and make a record of your observations. This is the scientific method, and no matter what you are observing, if you make a sufficient number of careful observations, record them accurately and draw from them a reasonable conclusion, you may call your work science, and yourself a scientist.

This is the kind of occupation which Dr. Louis Schroeder has been engaged in as a part of the community health work of the Association for Improving the Condition of the Poor. The educational value of such work is of the greatest importance because the public at large is helped by Dr. Schroeder's studies quite as much as the beneficiaries of the association. Those who read the article in this issue by Mr. Gebhart, director of the Association for Improving the Condition of the Poor, will find Dr. Schroeder's findings summarized, and in

The Twelfth Annual Meeting of The American Child Hygiene Association will be held in New Haven, November 2-5, 1921

some cases tabulated. The large number of children (2,186) examined within a period of six months, the fact that all were city children of practically the same kind of racial stock, and that all of the examinations were made by the same physician, gives a special value to these conclusions, and perhaps a unique freedom from the equation of error which sometimes vitiates the accuracy of grouped clinical observations.

It is of the greatest significance, therefore, that the studies made of 894 children ranging in age from two to six, should have shown the defects which are popularly attributed to that period and which are wholly preventable during the so-called pre-school age. Particular attention has been given to dental defects in the child of pre-school age, and in Dr. Schroeder's series 28 per cent showed defective teeth. The next group, aged six to twelve, showed 67.5 per cent with defective teeth, an argument which in itself proves the cumulative effect of disorders of dentition.

But it is the field of orthopedic defects that the importance of this study looms the largest. The general average of these defects in all children is estimated at 2 to 3 per cent, but among the 894 city children studied by Dr. Schroeder, 24.6 *per cent had orthopedic defects.* This incidence of orthopedic defects dropped in the next group to 7.9 per cent, the decrease occurring in defects of the extremities, the predominating defects in children from six to twelve being those of the thorax and spine. In other words, the minor defects corrected themselves, but those having the most serious consequences to the child's physique and future health, remained.

"Practically all of these defects had their origin in rickets," says the report. Soranus in his unknown grave will never know how modern science has corroborated his observation concerning city children. But the work of the Association for Improving the Condition of the Poor in this field is social service in the highest sense of the term, for it strikes at the cause of the ills that it investigates. If 24 per cent of all "neighborhood" city children in New York ranging in age from two to six are suffering from rickets, and if 7.9 per cent of older children have serious physical defects of the thorax and spine as a result, we have truly learned something of value. For rickets is a preventable disease, and these deformed extremities, these twisted spines, these flattened chests, which rob even childhood of its happiness, and blast the lives of men and women until sometimes their minds are as warped and crooked as their bodies—all these will disappear under the influence of a well-rounded program of State and National health education, aided and supplemented by the efforts of the local and national bodies.

—John Foote.

The Day's Work

WHAT NEW YORK STATE HAS DONE

SOME of the most important pieces of work done by the Division of Child Hygiene of the State of New York during 1920 are as follows:

The licensing and supervision of midwives was assumed by this Division the first of the year and efforts continued and extended to eliminate unfit and unworthy practitioners and to improve the work of those who were licensed.

Special departmental rules and regulations relating to day nurseries were promulgated and the supervision of these institutions was undertaken. Thirty-three were inspected and the necessary recommendations for the correction of defects found were brought to the attention of those responsible with very satisfactory results.

Limited supervision of children's boarding homes was also begun and a number of complaints investigated and acted upon.

The most outstanding piece of work undertaken and one which gives every indication of being productive of perhaps more definite accomplishments than any other single line of endeavor, is the conduct of children's health consultations in the rural sections of the State. With the assistance of local health officers and practitioners 2,714 children, including infants, and those of pre-school and school age, have been examined thus far in 99 municipalities, located in six counties in as many sanitary districts. These examinations, intended to discover existing disease, defect or disability, have resulted in finding 2,082 children (76.71 per cent) with defects. Of this number, 1,438 (68.9 per cent) had conditions requiring further medical observation and care, and 629 (30.2 per cent) needed correction in feeding and hygiene. In addition, through the stimulation and with the assistance of this Division, such consultations were held in a number of municipalities by local agencies. All children requiring medical care are referred for such services to their own physicians. Adequate follow-up work has already been instituted in many of the localities and a large number of the children have had their defects satisfactorily treated. The importance and value of these clinics lie in the specific personal appeal made by the discovery of existing disease, and the demonstration of the need for periodic examinations, proper hygiene and correction of defects, and for the provision of sufficient public health nurses and other agencies to carry on this work locally. The demand for this service has become very great; it is impossible to meet it. It is planned, however, to go into all sections of the State. Such consultations will be conducted in

some of the larger villages of seven sanitary districts, the work to be continued until weather conditions permit again entering the more strictly rural sections. — *Health News, New York Department of Health, February,* 1921.

CHILDREN AND HOUSING

A bill in the legislature of New York would make it a misdemeanor, punishable by a fine, for the owner of a dwelling to refuse tenancy to any person because of children.

It is reported that in Boston leases have been drawn with a clause reading: "This apartment is leased for a family of —— persons, and for each additional person in the family the rent shall automatically increase $10 per month." One man, whose family was increased by twins, was at once billed $20 more rent a month.—*Nation, April* 13, 1921.

RURAL HEALTH CENTERS

In New York, bills making possible the establishment of health centers to meet the problems of medical care in rural communities of the State have been introduced in the legislature. Similar bills were introduced last year, but failed to come to vote. Provision is made for children's clinics of various sorts and for school nursing and the medical examination and treatment of school children. Moderate fees are proposed for patients able to pay, and free treatment when necessary. *The State Charities Aid Association News, April,* is largely devoted to a discussion of these bills.

PIONEER NURSES OF PITTSBURGH

The District Nursing Service of the Irene Kaufmann Settlement, Pittsburgh, which was started in 1902, was taken over the first of this year by the Public Health Nursing Association. During the nineteen years of its existence the Settlement Nursing Service, which has always been public health work and not merely "visiting nursing service", has made important contributions to the health history of Pittsburgh, especially in relation to its work for children. It was due to the study and experiments of the Settlement that the city adopted medical inspection in the public schools and appointed a corps of school nurses. The Infant Welfare Division of the Department of Health also had its inspiration in the work of the Settlement to reduce infant mortality. The first Open-air School in the city was started on the roof the Settlement House, in cooperation with the Civic Club of the County. In 1918, an infant welfare nurse was added to the staff, and soon after, the first weekly baby clinic in Pittsburgh was opened at the Settlement House. The Settlement nursing service "blazed the trail" for the public health nursing service of which it now becomes a part.

SCHOOLS AS COMMUNITY CENTERS

A number of Detroit, Michigan, school buildings will soon be

opened for community purposes during the hours from 3 to 11 P. M. After a study of the needs of the various sections has been completed a worker of the Recreation Department will be sent into each district to organize the activities of the social agencies of the district, and open a center in the school building. —*Playground, April,* 1921.

MILK AS A NATIONAL AND INTERNATIONAL PROBLEM

In 1920 a questionnaire on the following topics was sent to the Red Cross Societies of the different countries: (1) The encouragement, if any, given by the State to breast feeding; (2) Number of wet nurses employed in this and previous years; (3) Steps taken by the State or local authorities to protect the handling and distribution of cows' milk.

The information gained by the answers to these questions was used in the preparation of an article on "Milk as a National and International Problem," by Lina M. Potter.

The results of the question in regard to breast feeding showed that in France, Germany and Switzerland a money allowance is made by the State to mothers who nurse their children. In Cuba an annual competition is held, open only to children who are breast fed, in which three cash prizes are offered of $500, $300 and $200, respectively.—*International Journal of Public Health, League of Red Cross Societies, Geneva, March-April,* 1921.

NEGRO HEALTH WEEK IN BALTIMORE

The Seventh Annual Negro Health Week was observed in Baltimore, beginning April 3. According to statistics of the public health service, the death rate among negroes has been decreasing since the establishment of Health Week, the reduction in infant deaths being especially noticeable.—*Baltimore Sun, April* 4, 1921.

PREVENTION OF BLINDNESS

Laws requiring treatment to prevent infant blindness were enacted in the last sessions of the legislatures of Iowa, Missouri, Oklahoma and Texas, and are under consideration in California and Connecticut.

Such a law is now in force in Wisconsin. The report of the State Board of Health shows that during a period of several years but one case of infant blindness has been reported, though before the passing of the law, blind babies were not uncommon.—*News Letter, Nat. Com. for Prevention of Blindness, N. Y., April* 1, 1921.

NEW USE FOR NATIONAL FORESTS

In California the opening of health camps for physically defective children, in the national forest reserves near centers of population, is proposed by the Federal Forest Service. Cooperation on the part of the cities is needed, and the service invites communications from cities interested, and will recommend to the chief forester the offers that give greatest promise of

success.—*San Diego Sun, March* 26, 1921.

OAK PARK GETS BIRTHS REGISTERED

To encourage birth registration a resolution requiring legal evidence of the age of all applicants for admission to the kindergarten and first grade of the public schools has been adopted by the Board of Education of Oak Park, Illinois.—*Health News, February,* 1921.

NEW MEXICO'S CHILD WELFARE BUREAU

A State Department of Public Welfare has been created in New Mexico, which includes a bureau of public health and a bureau of child welfare, to take the place of the former State agencies dealing with those subjects. The department will be under the control of a State board of five unpaid members, with a salaried director for each bureau. The existing child welfare building at Santa Fe will be used as headquarters for the activities of the child welfare bureau.

The State board is given power to cooperate with the Children's Bureau, or whatever agency may be authorized in carrying out the provisions of any bill which may be passed by Congress for the protection of mothers and babies.—*Santa Fe New Mexican, March* 17, 1921.

PENALIZING PARENTS FOR NON-SUPPORT

In Michigan an imprisonment penalty for parents who fail to provide adequate food and clothing for their children, whether the children are born in wedlock or not, is provided by a bill to be introduced in the legislature. A clause of the bill makes it possible in action brought under the proposed law, for a husband to testify against a wife or a wife against a husband. Care for the children of convicts is provided for in a section requiring penal officers to turn over to the probation officers $2.50 a week for each child of prisoners under their custody, the money to be expended by the probation officer. — *Detroit Free Press, March* 15, 1921.

KANSAS UNIVERSITY AND CHILD WELFARE

A Bureau of Child Research, to be established at the University of Kansas, has been authorized by the legislature. The bill carries no appropriation, but coordinates the personnel and equipment of all the State schools, hospitals and institutions. A conference of the child welfare workers of the State is soon to be called by the Chancellor to formulate plans of work.—*Topeka Capital, March* 23, 1921.

TEACHING THE TEACHERS

Six weeks' courses in health work for rural teachers are to be given in the State normal schools at St. Cloud, Minnesota; Dillon, Montana; Aberdeen, South Dakota, and Fargo, North Dakota. A course in nutrition will be given, including a study of children's diet; hygiene and health pedagogy will be taught and during the sixth week the subject will be the school as a health center and the problems of school health clinics.—*Modern Medicine, March,* 1921.

A WELL-ROUNDED STUDY OF CHILDREN

A study has been made of the first thousand children examined in the clinic for dependent children of soldiers of Montreal, maintained by the Canadian Patriotic Fund. This study has been reported by Helen R. Y. Reid, under the title, "A Social Study Along Health Lines". The fact that the families of the children examined were also on the records of the same organization afforded an unusual opportunity to study the social background, which makes the section of the report dealing with that phase of the study of special value.

Dangerous Maladies

WHOOPING-COUGH AND MEASLES

From a brief statistical study of recent experience with measles and whooping-cough in Massachusetts, Jonathan E. Henry, M. D., C. P. H., Epidemiologist, Massachusetts Department of Public Health, Boston, draws the following conclusions:

Propaganda and methods of control should be more specifically directed at the age group under three.

It cannot be emphasized too strongly that in these dangerous years, when so many children die of measles and whooping-cough or their complications, the most careful medical attention and nursing are needed to provent dangerous complications.

Approximately 33 per cent of the whooping-cough and 18 per cent of the measles in Massachusetts are in children under three.

For a period of years (1913 to 1918) 90 per cent of the deaths from whooping-cough, and 79.5 per cent of those from measles, have been under three years old.

The apparent fatality rates for the group under three, in 1918, were 23.5 per cent for whooping-cough and 8 per cent for measles.

For each thousand reported cases of measles in 1918 in Massachusetts there were 18 deaths, and 14 of these were under three.

In the same year each thousand cases of whooping-cough represented 92 deaths, and 77 of these were under three.

Even though there has been, on an average, four or five times as much measles, the whooping-cough fatality leads for the six years (1913-1918) with 2,065 deaths compared with 1,908 for measles. This is a total of 3,973 deaths from the two diseases, and 3,378 were under three.

Measles is more prevalent, but less fatal; whooping-cough less prevalent, but more fatal. In the end they cause almost equal numbers of deaths and should cause us equal concern.

Measuring our success by a reduction in deaths from these diseases it is at once apparent that our results depend very largely on how successfully we prevent measles and whooping-cough in children under three, among whom about 85 per cent of the deaths occur (90 per cent whooping cough; 79.5 per cent measles).—*American Journal of Public Health, April,* 1921, p. 302.

The Foreign Field

France

Health Aid in Schools of Trade

The trade schools of Paris have taken up physical education. The girl pupils are examined by the school physicians, in order to determine the amount of gymnastics they can stand. All girls are required to take three hours of gymnastics a week, except those who are found not strong enough for any physical exercise. An afternoon a week of sports is optional, and an hour of the gymnastics is used to get the girls ready for this. The other two hours are divided into one for ordinary gymnastics, and one for corrective gymnastics. The latter are intended to offset any bad effects resulting from the pupils' posture in the class room.—*La Protection de l'Enfance, February,* 1921.

Child Welfare Exhibits

During the time that the Child Welfare expositions were being conducted by the Children's Bureau of the Red Cross in central and southern France, there was no chance to carry this form of health teaching into northern France. However, in the spring of 1921, the American Red Cross and the Rockefeller Commission for the Prevention of Tuberculosis joined the French authorities in having Child Welfare expositions in Lille, Roubaix, and in other nearby towns.

In April, 1921, at the opening of the Child Welfare exposition in Roubaix, the townspeople sent a cable to President Harding, expressing their appreciation of the American assistance as symbolizing the "unalterable friendship existing between our two sister republics."

Six thousand persons visited the exhibition on the opening day, and widespread interest was shown through the district, many mothers bringing their babies from distant villages. A feature of the exhibition was a series of thirty original paintings of children by the celebrated French artist, Poulbot.

New Help for Old Need

The first school in France for children of arrested mental development has been recently founded by the general council of Cotes-du-Nord. It is in Crehen, near Plancoel.

England

Infant Welfare and Maternity Centers

According to the new list recently published by the Ministry of Health, the number of Infant Welfare and Maternity Centers up to January 1, 1921, is 1923 in England and Wales alone; 209 of these being in London, 440 in county boroughs, and 1274 in counties. Of the total number of Centers, 339 are conducted by county councils; 789 by local sanitary authorities; and 725 by voluntary societies.

Czecho-Slovakia

Existing Conditions and Needs

The following account of the conditions in Czecho-Slovakia is given by Dr. W. O. Pitt, Chief of the Department of Child Welfare, in the League of Red Cross Societies.

Bakova, a village a few miles out of Coca, where the Paget Mission has its headquarters, may be taken as an example of the villages throughout the country. The cottages are usually of wood, sometimes of stone and mud with wooden or thatched roofs. There may, or may not, be a chimney, and in the poorer cottages the windows are made so as never to open. The interior consists of one, or at the most two, rooms, containing a rough table, a bench and a bed, the latter resembling a wooden box frame. I have never seen more than one bed in any of the cottages, although some of the latter accommodate from three to four and up to six or eight persons. About a quarter of the room's space is occupied by a stove. In this village we saw children and adults with goitre, as well as several idiots and dwarfs.

There is much sickness and mortality among the children of Slovakia and the number of deaths is out of proportion to the sickness. It is certain that many deaths and permanent deficiencies (idiocy, and so forth) are due to under-nourishment, ignorance of hygiene, and unfavorable domestic conditions.

The Czecho-Slovakian Red Cross has decided to purchase the house and estate of Mr. Jan Kubelik, the celebrated violinist, on the condition that with funds provided by Lady Muriel Paget it should be organized and run for one year by the League of Red Cross Societies, as a child welfare center. The gift of two motor ambulances, presented to the League by the American Red Cross, will greatly facilitate the work and will enable the outlying districts to be reached.

At Uzhorod, the "Zupanat" doctor, who corresponds to a health commissioner, informed us that the health of children under two years in this country is usually better than during the succeeding period of five years; that tuberculosis levies a very heavy toll on the population (588 deaths out of a population of 105,000, pre-war estimate), that there was an epidemic of dysentery in progress and that goitre was prevalent, especially in certain valleys.

At Prague, the only child clinic is located in one of the schools. Its work, confined to the quarter in which it is situated, is carried on in a modest, but efficient manner, a woman doctor and nurses being in attendance. Careful records are kept, and we were interested to learn that out of a total of 900 babies who had been cared for in this clinic, only five were not breast-fed—a remarkable figure, compared with that of many other countries. —*League of Red Cross Societies Bulletin.*

Recent Literature on Mother and Child Welfare

Book Review

The Mother and the Infant. By Edith V. Eckhard. (The Social Service Library.) G. Bell and Sons, London, 1921, 6s. net.

In these days when officialism (disguised under the blessed name of expert) is running rampant through the land, it is interesting to find that the author of this admirable handbook bestows a good word on the voluntary worker. At the outset Miss Eckhard, of the Social Science Department, London University, admits that "the officials of the Public Health Service in many cases do not appreciate the immense possibilities for initiative and progress which voluntary societies can exercise if they are helped and encouraged."

Maternal care; sanitation; housing; day nurseries; nursery schools; the unmarried mother and her child; the training of workers — professional, nursery school, voluntary, and school girls—are the subjects dealt with by Miss Eckhard.

We should like to commend her words as to the invaluable services of the best kind of health visitor—whose existence was undreamed of a decade or more ago; whose value, nevertheless, is above rubies—if only local authorities could be induced to take long views. Let a carefully chosen health visitor be appointed for, say, every 5,000 inhabitants of an urban and 3,000 of a rural district. It is necessary that she should be a woman of good education, and have had two, if not three, years' training, both theoretical and practical; it is still more important that she should have "a natural love of children, and sympathy and understanding for their mothers". Besides this, she should be able to "get on with" her local committeemen and women, country practitioners, district nurses, and other "public health" officials. Many such women have already responded to the great need, but hundreds more are required.—*Common Sense and Ways and Means, London, March* 5, 1921.

With the May issue, the name of *Modern Medicine* will be changed to *The Nation's Health.* This is being done to make the title more clearly descriptive of the present scope of the magazine, which is devoted to community, industrial, and institutional health problems.

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MOTHER AND CHILD

A Magazine Concerned With Their Health

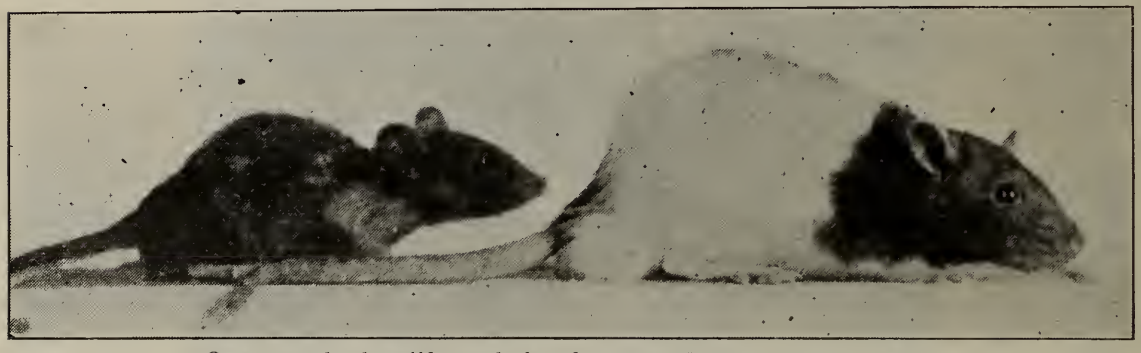
VOL. II JULY, 1921 No. 7

Solving Food Problems

Margery M. Smith
Director of the Boston Dietetic Bureau

JOHN LEE, fourteen years old, small for his age, and backward in school had been coming to a local dispensary for over a year. He was being treated for inflammation of the eyelids, but the condition of his eyes had not improved when the nurse referred John to Miss H., a nutrition worker on the Dietetic Bureau staff. At that time the boy's eyelids were inflamed, crusted, and without lashes. A call on his mother at home brought to light serious errors in the boy's diet including an abnormal craving for salt. John was eating few fresh vegetables and fruits and was taking no fresh milk but was eating freely of meat, white bread and salt. Luckily John came home while Miss H— was talking with his mother, and the nutrition worker took this opportunity to tell him the story of the two rats, at the same time showing their pictures which she always carries in her bag. John listened with interest. In the picture one of the rats was large, and fat and sleek; the other was small and poor, and rough haired. When Miss H. explained that the large rat had had milk and green vegetables to eat and that the small one had had none, John was quick enough to see that he was very much like the small rat. He did not eat green vegetables or drink milk and he was much smaller than other boys of his age. He was so thoroughly convinced of the error of his ways that he began at once to drink milk and with the help of his mother to eat more vegetables with less meat and much less salt. In two weeks the doctor noticed a decided improvement. The boy's eyes were better and he had gained in weight. In another week the eyes were practically healed and at the end of the fourth week the doctor reported John's eyes in normal condition. At the present time, nine weeks since the case was referred to the Dietetic Bureau, John's eyes are free from inflammation, his lashes have grown out and he

has gained several pounds in weight. Incidentally, John is spreading the gospel of milk and fresh vegetables in his neighborhood by telling the rat story to all his friends who can readily see the boy's improved condition.



One rat had milk and fresh vegetables. Which one?
Reproduced by courtesy of Dr. E. V. McCollum from "The Newer Knowledge of Nutrition."

Very recently John was further convinced of the value of milk by the pictures of the two dogs accompanying this article. They were the same age, but the dog who was taken to live in the country where she had plenty of milk and rolled oats to eat was twice as large as her brother who was left to fare miserably on a limited amount of city milk and dog biscuit. On one occasion, John remarked to Miss H— "I suppose the cats around here in the alleys have rough hair and sore eyes because they don't have milk enough to drink." It seems fair to assume that a corrected diet as a supplement to the dispensary treatment hastened the recovery of the boy's eyes, and that with right food habits well established there is less likely to be a return of the old trouble.

A young man slowly recovering from the effects of gas and a bullet wound received in service needed the best possible nutrition care. His wife, untrained and inexperienced, did not know how to provide suitable food for her convalescing husband or for her child one year old, a very fat, inactive, pasty looking baby with sores on his face. The Red Cross Home Service, which was temporarily aiding the family until the man could secure compensation money from the government asked the Dietetic Bureau to send a worker into that home to help the young mother plan, buy and prepare proper food for her family. A study of the income showed the worker who took the case that it was inadequate to meet even minimum needs. A suggested budget estimate for the family was accordingly presented to the Red Cross which granted an increased allowance. With a more nearly adequate income to work on, and with the interested cooperation of both the mother and father the nutrition worker's results soon began to show. The

father gained steadily until he was able to attend a vocational school where he is learning a trade. The baby also improved with a change in his diet from a proprietary infant food to fresh milk, fruit juices and other foods usually given to a child of this age. His skin cleared, his color improved, his fat flabby flesh became firmer. In two months time he was walking, and is now a well, active child.

FOOD SUPPLY AND INCOME

For some years social workers in many of the social agencies in Boston had recognized the seriousness and frequent occurrence in their families of just such food and budget problems as have been outlined. Believing that proper nutrition is essential to family welfare, the League for Preventive Work, at that time a cooperative effort of nineteen social agencies made a study of the "Food Supply in Families of Limited Means". The study indicated that there was indeed a serious food problem in fully one third of the families known to welfare agencies. It was often true that enough money was spent for food, but that the food was unwisely purchased and unsuitably prepared, particularly for growing children. On the other hand insufficient incomes frequently explained food problems. The results of this food study stimulated a further recognition of the importance of proper nutrition and in July 1918 aided by a Permanent Charity Fund, the League for Preventive Work established the Dietetic Bureau.

THE DIETETIC BUREAU'S WORK

The Dietetic Bureau is a central organization to which agencies and individuals in the community may come for help in solving food problems in families known to them. One method of approaching food problems is through direct work with individual families as in the case of John Lee and the Red Cross family already mentioned. A family is referred to the Bureau by any social worker in any social agency. The work in the home is then done by women well trained in the science of nutrition and at the same time so familiar with home conditions and with food economics that they are able to suggest the most economical yet practical diets which will provide adequate nourishment. In every instance it is necessary to keep in mind the relation of food expenditures to

other items in the total family budget. An understanding of diets for certain diseases is second in importance only to diets for health, especially diets for growing children. The worker who knows and respects the diet characteristics of other nationalities will be the most likely to be successful in helping such families supplement or change their food habits to meet health requirements. It is by no means a trivial matter to adjust family food habits. Even with infinite tact and patience the nutrition worker may not always succeed in carrying out her plans, but in many families through a gradual process of education successful food adjustments can be made.

TEACHING HEALTH HABITS

Children are more easily influenced than adults and those of school age can be effectively reached in groups by encouraging a spirit of friendly competition at the weekly class meetings. To make the greatest gain in weight for the week is an honor to be strived for and eating vegetables, drinking milk, brushing the teeth and going to bed early are seen by the children in a new light as a means to that end. It is the common experience of investigators that faulty nutrition is invariably one of the defects brought to light in an examination of any group of children physically below par. The malnourished child is usually not only a victim of faulty food habits, but of other bad health habits and conditions as well. Consequently he may suffer from bad posture, diseased tonsils carious teeth and other defects which must be corrected before his condition can be much improved. With diseased tonsils, adenoids and carious teeth removed there still remains in many instances a very important part for the child himself to play, that of adjusting his daily habits of eating and drinking, posture, sleep, rest, exercise, and cleanliness. One purpose of nutrition work with groups of children is to help them form habits essential to health for good nutrition is dependent on a sound body functioning properly. Right health habits may be encouraged in the nutrition class but the real struggle of overcoming bad habits must be made by the child and his mother at home day by day. Their effort and success will depend somewhat on income and other home conditions and very much on the nutrition worker whose influence in the class room and in the home can win and hold the interest and cooperation of both the mother and child. The influence of the nutrition worker in turn will depend on her nutrition and social training, on her physical fitness and in large measure on her personality. After three years experience with nutrition classes the Dietetic Bureau believes that until the public schools are equipped

and ready to give health instruction to all our boys and girls from the kindergarten through the grades and high school, it is distinctly worth while for private organizations to continue nutrition work with special groups of children as an effective way of stimulating further interest in the health of all children.

Evening Class in Day Nursery

Our classes have met in dispensaries, hospital out patient departments, settlement and neighborhood houses, health centers, child welfare stations and day nurseries. The Sunnyside Day Nursery nutrition class is an example of our group work with children. Each child was given a careful physical examination and arrangements were made for clearing up the more obvious defects of the teeth, tonsils and adenoids before the class began. This class meets on Monday evenings from seven to eight o'clock in order that the mothers who work away from home all day may attend the class with the children. As each child arrives he unlaces his shoes and forms in line by the scales for the weekly weighing. The interest of the mother is hardly less than her child's as she eagerly waits to hear the gain for the week. When the individual weight charts are all hung in order of the weekly gains, the greatest gain at the head of the line, the nutrition worker discusses the charts with the mothers and

children. Reasons for gains are emphasized, reasons for losses are noted, but most stress is placed always on the positive gaining side. A short talk to the mothers and children follows. Usually one type of food and one health habit is presented. For instance, one lesson was on the use of whole grain breads and chewing food thoroughly. To help make the lesson real, the children were given small sandwiches of entire wheat bread to see if they could chew each mouthful at least twenty times. To the splendid cooperation of the nursery, the mothers, and the children with the nutrition workers in charge is due the success of this class.

The attendance has been excellent, not once has a mother failed to come with her child. Since the mothers are all away from home during the day it is not possible to do any home follow up work, and for this reason it is doubly important to have the mothers attending the class regularly. The children have made extraordinarily good gains. During the second week of the class three tonsilectomies were followed by heavy losses but in from one to three weeks time these losses were all recovered. The gain in weight is gratifying, but even more gratifying is the improved color, the firmer flesh, the brightened spirits, and the more vigorous health point of view which is increasingly apparent each week. When a child

Signing the following Home Rules of the Health Game is made quite a feature in the Nutrition Classes. Thumb tacked to the wall in the kitchen at home the card serves as a daily reminder to both parents and children. More than once has a father's interest been won by the Home Rules, and not long ago one child was heard to say to another, "Oh, but you must eat it; the card says so."

Home Rules of the Health Game

In order that I may weigh as much as I should and be as well and strong for my age as all loyal American girls and boys are proud to be,

I ..... *agree to try to:*

1. Go to bed every night at..... o'clock to sleep ..... hours with windows open.
2. Sit, stand, and walk tall and straight.
3. Have a bowel movement every morning.
4. Take a full bath more than once a week.
5. Brush my teeth at least twice a day, after breakfast and just before bed time.
6. Wash my hands before eating.
7. Drink at least a pint of milk a day. (No tea or coffee.)
8. Eat at least one vegetables besides potato every day.
9. Eat some fruit, fresh or dried, every day.
10. Eat cereal every morning for breakfast. (Home cooked cereals are best.)
11. Remember that meat every day is not necessary.
12. Eat an egg a day when they are not too expensive.
13. Drink a glass of water before each meal and at bed time.
14. Eat slowly at regular hours, and chew my food well. (No candy between meals.)

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gleefully tells the nutrition worker that he has learned to like spinach, another that she saves her pennies for fruit instead of candy, a third that she is going to bed earlier, a fourth that he doesn't drink tea any more and a fifth that he never goes to school now without breakfast it is truly an occasion for great joy since it means in each case a growing health consciousness.

In addition to doing field work in individual families and with groups of children the Dietetic Bureau gives advisory and informational service to the social agencies in the community. It is not possible or even desirable to send a trained nutrition worker into every family where there is a food preblem, but it is possible through individual and group conferences to inform and advise social workers how to adjust the less acute food problems which they are meeting in their families every day. To further help social workers and others interested in food problems the Bureau prepares printed sheets embodying as far as possible recent scientific data bearon nutrition. Since much food information can be more effectively presented to both children and adults through pictures and graphic representation than by word of mouth or by the printed page the Bureau considers the collection as well as the preparation of illustrative material, charts and posters an important part of this work. It is also the aim of the Bureau to keep well enough in touch with some of the current nutrition and other health literature now in circulation to have an up to date bibliography of the portion of it adapted to nutrition work.* Outside the strictly social field the Bureau answers local calls for speakers and materials from teachers, parent teacher associations, women's clubs, child welfare study clubs, and church societies. In addition thousands of sheets of printed material have been sent from the Bureau into many states to a variety of institutions.

Through an arrangement with Simmons College, a course in Social Service Dietetics is offered to students of Home Economics who are given an opportunity to apply their knowledge of nutrition in group work with children and in families needing instruction in food and budget adjustment.

The Dietetic Bureau has watched with interest the growing conviction that proper nutrition is of primary importance in health particularly in the health of children. With others the Bureau believes that the most effective preventive work along nutrition lines can be done with the pre-school child whose daily health habits are just in the making. Though nutrition specialists are comparatively new in public health work, those who are in the field have shown convincingly the need of a nutrition service in any community health program.

*See list on pages 331 to 336.

Benjamin Broadbent, the Babies' Mayor

[This story of how the Notification of Births Act in England and Wales was secured was written for MOTHER AND CHILD by Mr. Broadbent, formerly the Mayor of Huddersfield.—Editor.]

I DO not know whether the readers of "MOTHER AND CHILD" will be interested in an account of the origin of the Notification of Births Acts in Great Britain. I leave to the editor the entire responsibility of deciding whether or no this story, or any part of it, is likely to be of any service in the promotion of the work of the American Child Hygiene Association. Judging from the report on Birth Registration, published in the March number of "MOTHER AND CHILD", I think it might possibly be useful.

At the beginning of this century the chairman of the Health Committee of Huddersfield, a provincial town in the North of England, happened to be one who took his responsibilities somewhat seriously; he conceived that by virtue of his office he was in charge of the public health of the town; to him the rate at which his fellow-citizens died was a matter of keen solicitude. When a low death rate was reported it was a personal gratification to announce it; when the death rate was high, he took it to himself as a reflection on the imperfect discharge of his own particular functions. For many years this interest in the fluctuations of the communal health was general and, therefore, vague. But in the year 1903 or thereabouts, the Medical Officer of Health of the town, the professional adviser of the Health Chairman and head of the Health Administration — in the course of conversations on the carrying out of the health activities of the department, called the special attention of this chairman to one particular item in the statistical records which affected the death rate most markedly; that was the large number of deaths of infants under five years of age and particularly of babies under one year of age. This fact struck the chairman as very pitiable and pathetic, but there followed the inquiry—was there any reason for these untimely deaths? The Medical Officer could say that the town was no worse in this respect than many other towns, indeed it was better than most of the towns with similar industries and similar climatic conditions. There was nothing specific to be alleged against the general sanitary condition of the town. This did not satisfy either the Medical Officer of Health or the Chairman of the Health Committee; it was agreed

between them that inquiry must be carried more into detail. The Medical Officer proposed that he should be authorized to make an investigation over a series of years, as to the exact cause (so far as could be ascertained from the death registration) of the death of every baby dying under one year of age. The deaths were classified as far as possible under the three headings, preventable, doubtfully preventable, and non-preventable. The result showed clearly that a very large proportion were certainly preventable —in other words, that very many babies died through causes which were remediable. This was a piece of definite and incontrovertible fact, and to the Chairman of the Health Committee, with his notions of responsibility for the physical well-being of his fellow-citizens, it was a very poignant fact. It seemed monstrous that these little helpless beings should be allowed to die from causes which could be removed; the question was how far did responsibility for these deaths rest upon the Health Administration of the town? Clearly this was a case for some kind of action to be taken. Accordingly, the whole subject of infantile mortality was brought before the Health Committee and the Medical Officer was instructed to prepare a report and submit it to a specially constituted sub-committee, to be called the Infantile Mortality Sub-committee. The report was prepared and submitted, but apart from the chairman and Medical Officer very little interest was shown—so meagre was the attention given to it that for month after month no quorum of the Infantile Mortality Sub-committee could be got together; the report and the whole matter was moribund. It may be said here that the medical officer's report was at that time unique in the completeness with which the facts relating to infant life and health were brought together and up to the present time it is still alive and has taken its place as a record-making document. It may be left to imagination as to what the period of enforced inaction meant to the chairman; open opposition could be fought, but mere deadly apathy and indifference—the refusal even to listen to any allusion to the subject—how could these be overcome or grappled with? The thought of the needless suffering was horrible and the wail of dying babies broke the sleep of the too sensitive chairman.

What was to be *done?* To do nothing was to fret and wear away vitality. The relief came in a way that was entirely unexpected. The Chairman of the Health Committee was invited to occupy the office of mayor. What combination of circumstances had made it possible for such an invitation to be given to one who had always steadfastly refused to belong to any party in the town council—one, too, who was already counted to be a faddist in health matters? There is no answer to the question, except, possibly, that a refusal was expected. However,

the invitation was formally given with the assurance that it came from all parties and would certainly be endorsed by the town council. It was a matter for grave consideration, but the one determining question was, could the Mayor — *qua* Mayor—do anything for the babies? The Chairman of the Health Committee had failed, would the Mayor be able to do anything? A mayor in a provincial English borough is still a personage. He takes precedence of every other man in the borough; he has no superior within his town, except the King's Majesty himself, or the King's direct representative. It looked quite possible that if his heart were really set on it a mayor might get something done by throwing the whole of his official weight into the scale. The invitation was accepted and from the moment when his decision was made the most careful thought was given as to how the official position of the mayoralty might best be used in the interests of the babies of the town.

It was at a very informal and entirely unofficial meeting when the plan of operations was laid down—the Medical Officer and his wife, and the Mayor elect and his wife, formed the meeting. All of them profoundly interested for many months past and each with thoughts of their own as to what could, should or might be done. Quite suddenly the scheme crystallized itself out, complete and unanimous, yet quite simple. It was found possible to develop the idea in several different directions, but the particular line in regard to the notification of birth is the only one which can be followed here. It was agreed that one great object to be aimed at must be to gain an early knowledge of the new arrivals so as to afford some direct and immediate help and encouragement to the mothers. At the time none of those concerned understood how extremely difficult it would be to obtain early information as to the birth of an infant. It was thought that the publication of that part of the scheme which promised a birthday present on the first anniversary of the baby's birth would prove a sufficient inducement to the parents for one of them to give the required early notice of birth. For the first three months after the Mayor had promulgated his promise it seemed as if this object would not be secured at all, as the mothers of new-born babies were about the very last to learn that there was any scheme on foot for helping them at all, or for showing an interest in the welfare of their babies. Even when they were told about it and the Mayor's promissory notes were given to them at first they were entirely skeptical as to the bona fides of the mayor.

It may be explained that the English registration law allowed forty-two days after the birth for registration, and it was the custom to wait till this period had nearly elapsed to see if birth and death might not be registered at the same

time! Yet it was during that very period of forty-two days that the question of the life or death of the infant was decided so frequently, and still more frequently was decided whether the whole future of the child should be sound and healthy or sickly and unwholesome. To alter the registration law was a herculean task in the face of all the vested interests and inveterate customs involved and the attempt in this direction was abandoned. Yet the urgency of getting to know early about the birth became more and more manifest, and still the difficulty seemed well-nigh insuperable.

Can it be considered less than a stroke of genius to have suggested that the question might be solved by a system of voluntary notification on the part of doctors or midwives or parents or anyone else, with the inducement of a small fee for the information? The idea was embodied in the plan which the Mayor and Medical Officer of Health worked out and prepared for submission to the town council. A fee of one shilling was recommended for each notice of birth within forty-eight hours, such fee to be payable to the first informant. It was intended to follow up the notification by an immediate visit by duly qualified medical women in each case.

The babies were then to be placed under the observation of voluntary ladies who would keep in touch with the mothers and report to the health office as to the progress of the babies. There were other parts of the plan which do not concern this story. The scheme was very nearly wrecked at the outset in spite of all the official influence of the Mayor, Some parts of it had to be jettisoned to placate the opposition and it was only by a very small majority that the Town Council authorized the attempt. Fortunately, the early notification was one of the items that survived the opposition and retained its place as an integral part of the whole scheme. Public attention was specially attracted to this and much ridicule was poured on it; one paper was so maladroit as to say that in attempting to save the lives of Huddersfield babies the town council was out-Heroding Herod, whose fame—or infamy—rests on his slaughtering the babies of Bethlehem. There were funny pictures of rival informants racing to the Health Office to be the first to get the shilling. And so forth. But grudgingly as the sanction was given there was no loss of time and no lack of zeal in putting the scheme into operation.

In a comparatively short space of time—some four to six months after the Mayor's assumption of office—those who were chiefly concerned in the scheme—the mothers and fathers—got to understand it and even began to appreciate the good it was capable of doing. What with the Mayor's promissory notes, and the fee for prompt notification, and the zeal of the Medical Officer

and his new staff, and the practical though tentative work of the ladies of the Public Health Union, there was a real attack made upon the various evils, especially ignorance, which caused so many infant deaths, and so much enfeeblement of health in those that survived.

The results were very quickly perhaps even more valuable, if less manifest, was the rapid accumulation of facts bearing upon the welfare of mothers and infants. The careful study of these facts was most useful in giving clear indications of the right lines upon which to proceed. The differentiation of the more effective from the less effective parts of the work became possible, and this again enabled effort to be concentrated on essentials, whilst the less useful parts were abandoned or subordinated. In Huddersfield it was evident at an early stage that milk depots and day nurseries, and even schools for mothers and infant clinics were of less value than home visitation and direct instructions in the home by the fully qualified women doctors, followed up by the tactful and sympathetic visits of the voluntary helpers—the links between the mothers and the health administration. In the words of the Medical Officer of Health, the *mot d'ordre* of the whole scheme was—help the mother in the home to care for her own baby.

As this home visitation showed itself to be more and more valuable the one point of getting to know, at the earliest possible moment, of the birth became of the most insistent value. The voluntary plan of giving a small fee was, indeed, successful to an astonishing extent. A large percentage of the registered births were notified to the Health Office within the prescribed forty-eight hours. But it was known that of the unnotified births a considerable proportion were those which were the most in need of supervision and help. To the careless and indifferent the fee of one shilling was no inducement; to the small class of vicious and semi-criminal parents, concealment till the baby was safely dead was deliberately preferred; by such parents the baby was unwanted and the less that was known about it the better, so far as they were concerned. It was entirely unsatisfactory to leave these poor babies outside the scope of the helpful measures of the Health Office and Public Health Union. Gradually it was forced on the Mayor and the Medical Officer of Health that something more than voluntary notification was necessary, if all the babies were to be saved. The hateful word compulsion came into the discussion. The Medical Officer has to plead guilty to inventing the phrase Compulsory Notification of Birth, but the Mayor was accessory after the fact, and both went in for compulsion—"bare-sark", if you will. On his own hook, the Mayor made inquiries throughout the whole civilized world as to what was done in

the way of ascertaining the arrival and looking after the welfare of new members of the state. Immigration of adults was provided for, but indigenous arrivals by birth were only noted in very casual ways and nothing was done to protect them. In particular it was amazing to the investigator how imperfect the laws were in America in relation to births. The main result of the inquiries was that there was nothing anywhere that could afford guidance as to compulsory notification of birth with the specific object of caring for the health of the newly born. The idea was new and untried, but if the babies of Huddersfield were to be given their proper chance of life and health there was no other course open. How was it to be done?

By this time the Mayor had been invited to a second year of office and it so happened that during that year the Town Council had to promote a bill in Parliament to obtain certain powers of a miscellaneous character which do not concern us here. To the Mayor and Medical Officer this seemed to be the opportunity for inserting, amongst the many miscellaneous clauses of the bill, a modest little clause conferring on the Town Council the power to have all births in the borough compulsorily notified to the Medical Officer of Health within forty-eight hours, for which notification the one-shilling fee was to be continued to be paid. It is perhaps rather unkind to refer to the opposition with which the proposal to insert this clause was received. The medical profession of the town opposed it, but let their objection lapse on the sacrifice of another clause—notification of tuberculosis—still more objectionable to them. The legal adviser of the corporation said it was impossible to think of obtaining such a power—it was absolutely new—it would create a new offence—it would be difficult to draft; in fact, he declined the task. So the Medical Officer had to draft the clause himself and, be it understood, it was only because the Mayor used all the weight of his official influence that the clause had any foothold whatever. The Parliamentary agent in London at first was just as definite as the local legal adviser in declaring that the clause was impossible. Still the Mayor held on to his dictum that whatever is in the bill or whatever is left out of the bill that clause goes in.

So the clause got into the bill. What would Parliament do with it? What would the Local Government Board—Mr. John Burns—have to say to it? Meantime, a curious change of attitude came over the legal advisers. Whether through the unreasoning enthusiasm of the Mayor and his determined insistence on the clause, or through the cooler argumentation of the Medical Officer of Health, the Parliamentary agent became almost as eager as the Mayor himself to get the clause through, if possible. It

is, of course, rather a feat for a Parliamentary agent to get an entirely new power for his clients and perhaps this little human touch may have had something to do with the change. Anyhow the invaluable help of the legal authorities was wholly won, and everything was devised that could be devised to make the clause presentable.

It would take too long to give details of the Parliamentary proceedings. The bill was referred to a select committee and before the committee the whole subject of compulsory notification was discussed. The evidence was carefully prepared; the medical aspect was presented by Sir William Broadbent, the Mayor's brother; undoubtedly this carried the case. The practical working was evidenced by the Medical Officer of Health and what may be called the unofficial and amateur side of the question, the Mayor had in hand. The incalculable, unknown powers of the Local Government Board, in whose hands lay a sort of power of veto, which seemed to threaten to overwhelm the poor little clause, suddenly gave way. The Mayor was told afterwards by the President of the Board that the promoters of the clause were pushing hard at an open door. That was not manifest at the time; the door seemed locked and barred, and nothing was more surprising than the sudden removal of what seemed, from the outside, an irremovable obstacle—the clause, so to speak, almost tumbled through. When the Local Government Board let the clause through in this rather undignified way the course was clear. The chairman of the Committee of the House of Commons—may his name, J. W. Wilson, be written in letters of gold wherever the story goes—gave to the counsel for the bill and to the Parliamentary agents, to the various witnesses and to the corporation itself, the highest possible compliment in announcing the adoption of the clause; the case for new power sought for "had been admirably presented to them, both by the witnesses individually and by the corporation generally, and it has come in a form in which the committee are always inclined to favorably consider a new precedent". The committee were unanimous in giving the clauses.

So far, so good. But there was still the House of Lords—that most dignified and conservative body of legislators in the whole world—what would they care about babies? What would they have to say about this novel piece of legislation? As a matter of fact, during the passage of the bill through the House of Commons the bill had become an "unopposed" bill, and in the ordinary course of procedure it would be accepted by the House of Lords without further investigation or debate. But it had to pass the scrutiny of the Lord Chairman of Committees of the House of Lords. Thus the position was simple, but by no means easy. In the hands of

one man lay the whole power of the House of Lords to pass, or not to pass, every clause of the Huddersfield bill. It was now a devouring anxiety to the Mayor to get that Lord Chairman to understand the Baby Clause—to the Mayor, the rest of the bill was very little, to him Clause 76 was the bill, the whole bill and nothing but the bill; and one man had it in the hollow of his hand—no discussion, no appeal, his fiat was final. What a position! It was not proper for the Lord Chairman to receive any kind of representation direct in reference to any bill that should come before him; he must decide all issues on his own. Whether right or wrong, something had got to be done, if only to ease the mind of the Mayor. Through the kindness of a member of the Upper House the Mayor got an introduction and an interview with the Lord Chairman's private secretary and had a long and most satisfactory conversation with him. This may be revealing what ought to be carefully hidden, but no matter now, it is ancient history anyhow.

So the bill hung suspended like Mahomet's coffin by a single hair till the fateful day, when the bill was to be considered by the Lord Chairman of Committees. The Mayor, with the various chairmen of the corporation committees, with all the officials — Parliamentary agent, Town Clerk, Borough Surveyor, Medical Officer of Health, filed into the private room of his Lordship—a bluff, ruddy, farmer-looking lordship he was, well known as a thorough good sportsman. He sat with his advisers, his private secretary at his elbow, at a long table separating him from the corporation people, who stood in a row like a lot of sixth-form boys called up before the headmaster to receive a reprimand or some solemn communication. The proceedings commenced; the headmaster—that is to say, the Lord Chairman of Committees—at once began to go rapidly through the clauses; this stands —what about that? The proper official replies. "No," says the Lord Chairman, "we can't do with that," and out it goes. And so on, clause after clause. At last Clause 76—Notification of Births. The Mayor's heart is in his mouth; what is the old chap—his Lordship, the Lord Chairman of Committees—stopping for? He is whispering to his private secretary and the private secretary gives a glance in the direction of the Mayor, which relieves the Mayor's suspense. "H-m, ha, yes!" says his Lordship. "This is a new hare Huddersfield has started. I suppose we must let it run."

Thus it was that the first Notification of Births clause with compulsory powers passed the British Parliament, and in due course was signed by his Majesty the King and became law, Law, that is, for the town of Huddersfield for a tentative period of five years.

The actual working of the powers thus conferred proved to be per-

fectly smooth and easy. From the first nearly all births were duly notified and the benefit of the knowledge thus acquired was quite clear and definite. There was never any difficulty in administering the law; the penalty for infraction has never had to be enforced from that day to this.

So successful were the operations under the act in Huddersfield that in the very next session of Parliament an act was passed giving powers to all health authorities to put compulsory Notification of Births into effect by a majority vote of the authority. Within a very few years all the large cities and boroughs and many of the counties adopted the act, which was found everywhere to be perfectly practicable. In 1915 the act was made general and so became applicable throughout the whole of the United Kingdom of Great Britain and Ireland. So at last the hare which Huddersfield started has its run throughout the countries governed by the British Parliament.

It is now generally acknowledged that without the powers given by these acts the very foundation of all work for maternal and infant welfare would be lacking. Every effort proceeds from that as its basis. Before the act came into operation the infant mortality figure was over 150 per thousand births; last year it was under 80. Nor must it be forgotten that the benefits which the whole work has secured are not to be measured merely by the lessened death rate under one year of age; the deaths between one year and five years have proportionately diminished, and the health of the whole mass of survivors is bettered by the new conditions which have saved life. Life and health have alike been preserved to an extent that would have appeared incredible a few years ago, and with more life and better health has come also increased human happiness. Many causes have contributed to this great result, but it may at least be suggested that the door was opened by the Notification of Births. Probably if the Mayor and Medical Officer of Health of Huddersfield had not led the way, someone else would have done so. Just as if Columbus had not discovered America someone else would have found it. Let it rest at that.

The Baby Crop of 1920

Philip Van Ingen, M. D.

Each year a great business concern balances its books in order to estimate carefully the success of its efforts. Its expenditures are figured out to a cent, as well as its profits. The cost of each department or activity is balanced with its earnings. The greater the margin of profit, the greater the success. If we are to carry on wisely the greatest of businesses, the protection of the health of our citizens, we should balance our books each year and see where we stand. Sir Arthur Newsholme said, "Infant Mortality is the most sensitive index we possess of social welfare. If babies were well born and well cared for, their mortality would be negligible." There are 657 cities of over 10,000 population where bookkeeping of "expenditures" is carried on. These are the cities in the Death Registration Area of the United States. In 492 of these cities "income" is also recorded, and they constitute the cities in the Birth Registration Area. The percentage of "income" expended on "costs" measures the success of business. In our business the recorded births are our income,—the deaths of babies our expenditures—the Infant Mortality Rate is the measure of our success. What kind of year did we have in 1920?

It will be noticed that Pennsylvania, Virginia, North Carolina, Ohio, Kentucky, Wisconsin and Utah have lower records than in any year of the five, while California, Indiana, Maryland, New Hampshire, New York and the District of Columbia have lower rates than in any year except 1919. The latter year was one particularly free from respiratory diseases, while during the early months of 1920 they were very prevalent. Particularly gratifying are the figures from Kentucky, Maryland, North Carolina and Virginia. The last two have a large colored population and the Infant Mortality Rate among negroes is always very high.

As in other years, the Pacific Coast States have a splendid record,—Oregon being 58, Washington 59 and California 68. Only two cities in California have a rate of over 100, one in Washington and none in Oregon. In the Birth Registration Area 69 per cent of the cities reporting are under the 100 mark, and 64 per cent of the remaining cities, 111, are under 70.

In years past the smaller cities, from 10,000 to 50,000 population, have been the ones where progress, as estimated by a falling Infant Mortality rate, has been slowest. It is encouraging to see that this year it is this group which shows the greatest improvement, the rates being even lower than in 1918.

The American Child Hygiene Association has attempted to tabulate and compare the figures, so that cities all over the country may be able to judge. Through the assistance and cooperation of local and State health authorities and Registrars of Vital Statistics,

	1916	1917	1918	1919	1920
California	70	70	73	64	68
Connecticut	101	93	106	86	94
Indiana	104	101	104	89	96
Kansas	75	98	106	88	96
Kentucky	101	103	119	105	87
Maryland	120	117	147	98	103
Massachusetts*	101	97	115	89	92
Michigan	108	99	100	97	102
Nebraska	78	75	88	83	87
New Hampshire	132	132	124	101	103
New York	97	93	98	85	88
North Carolina	158	159	160	124	104
Ohio	107	102	100	94	88
Oregon	54	58	74	69	58
Pennsylvania	114	113	129	99	96
Utah	71	66	66	74	65
Vermont	128	108	119	121	114
Virginia	132	129	144	106	100
Washington	59	62	67	59	59
Wisconsin	100	92	99	94	87

within six months of the end of the year, figures from 519 of these 657 cities have been secured, tabulated, charted, and are available. Practically every city in twenty-one states,—nineteen Birth Registration and two Death Registration States,—have been secured. Of the total, 420 of these cities are in these States. The State Infant Mortality Rates, which are not published in the report, may be of interest and are given here, with the comparative figures for the previous four years.

The Infant Mortality Rate for all cities reported, comprising a population of over forty-two and one-half million, or over 85 per cent of the total urban population in the Death Registration Area, is 90. The figures for the last five years are given for comparison:

Infant Mortality Rate—1916, 101; 1917, 98; 1918, 107; 1919, 89; 1920, 90.

In checking up our books we may say that the last two years have been most encouraging. If this rate may be regarded as fairly close to that of the entire United States, it means that 25,000 less babies died this past year than would have had the same conditions existed as did even five years ago! But it is not enough. A baby ought not to have "less chance to live a year than an old man of ninety".

*Incomplete.

The Nurse in Relation to Child Conservation

Jane Van de Vrede, R. N.

Director, Nursing Department, Southern Division American Red Cross.

"The attitude of a nation toward child welfare will soon become the test of its civilization."—Herbert Hoover.

THE work of a public health nurse in child conservation finds its Alpha and Omega in the work of the physician and the dentist. While all three work for the same general object, the nurse encounters certain difficulties which do not present themselves to the other professions.

It is universally recognized that a physician, or a dentist, has a definite health work to do. They are authorities, so to speak. The work of a nurse exists to make effective the aims and purposes of the other two. She reaches these through quite different channels, and she must so approach individuals and families as to be able to interpret to them the objects which should be reached in a health program.

The nurse must recognize that her services in the field of public health are new; that while she may be misunderstood at times, yet she has to deliver a message with a two-fold purpose—to make effective the work of the physician and the dentist by explaining the necessity for it to the people, and to impress the people with the advantages of securing the service they are prepared to give.

While the doctor and the dentist have the advantage over the nurse in that their technical services are immediately understood, on the other hand such services are naturally associated with the phase of supply and demand and carry with them an idea of possible financial advantage to the practitioner. It is apparent to those using the services of a public health nurse that not even in the most indirect way does her service redound to her individual financial interest. In other words, in families who are urged to consult a physician or a dentist because of defects noted, there may be a subconscious feeling that "Of course, he wants the fee". This feeling does not exist in the case of a nurse who is known to be employed by a given agency, and who does not secure personal fees. When fees are paid for her services they are paid directly to the agency employing her. On purely utilitarian grounds, the nurse has an entree in the home which may be denied the doctor, and for this reason her work may prove of special value to a health program from an educational, if from no other, viewpoint.

All agents are necessary to complete success, but the nurse does make her own contribution to child welfare and health. Fortunately for the children of today, science has decided that no concerted effort is too great, no technical knowledge too minute, to be used in determining the need of individual children and then of filling this need as perfectly as is humanly possible. On the other hand, in our present social system no agency, however perfect, can possibly be applied to the individual child without the consent and cooperation of the parents or guardians of the child, and one of the most important contributions that a nurse may make to health work, is to secure a full understanding and acceptance of it by the parents, and more particularly by the mothers, of children. Here the nurse is aided by the divine instinct of parental love. The nurse finds one of the most difficult problems solved by calculating wisely on this emotion, and enters many homes as a welcome and honored guest because she comes to help the children, when otherwise she might not be permitted to enter at all.

THE SCHOOLROOM THE KEY

The schoolroom, therefore, may be considered as the keynote to the situation in a new territory. Let us suppose this potent stronghold has also been selected by the county health officers, by the physicians, dentists and specialists of a given community for a joint point of attack, and a sweeping announcement has been made that the children in the town or county are each one to be subjected to a physical examination. The public health nurse might give a series of short talks to teachers, bringing out certain facts, as, for instance, that of the 22,000,000 school children in the United States, at least 14,000,000 have been found to be defective; that no doubt a proportion of these children are found in the schools of the county in question; and that in order to determine the degree of physical inefficiency presented, the examination should be made. The examinations may be conducted with little or no interruption of the regular school work; consideration should always be given to the work of the school-day by the health officer or physician directing the school examinations.

EDUCATIONAL WORK

The nurse finds her educational opportunity in the schools. Teachers are usually keen to see the need of health education, but are especially anxious to have their pupils make a good scholastic showing, and if they should be slow in cooperation in regard to the physical examinations, the nurse can explain how a child's condition is effected by malnutrition, adenoids, diseased tonsils, defective vision, hearing, lung or heart disease, hookworm, malaria, etc. The large percentages of such defects which have been discovered in the 22,000,000 school children will impress the teacher anew with the possibility of her pu-

pils being among the defective number and of the futility of her own work when matched against physical handicaps..

When the examinations are regularly established, the public health nurse is supplied with standard cards on which defects are marked. Mere physical examinations and determinations of defects do not promote health until defects are corrected; and when a public health nurse follows up the cases, a greater improvement in the health of the school children has been noted. The following figures are indications of the nurse's contribution. The percentages are based on two groups of 1,358 and 1,780 children found with physical defects in Philadelphia schools.

	With nurses' aid	Without nurses' aid
Recommendations of physicians acted upon.....	89%	24%
Treatment obtained for teeth	92%	20%
Treatment obtained for eyes	80%	26%
Treatment obtained for adenoids	73%	14%
Treatment obtained for tonsils	65%	18%

The value of a health campaign for children, beginning with the school, has been touched on first because it presents the most tangible angle at which a nurse can touch the work of the health officer and the local physician and by which the entrance into the home may be made in the most natural way.

FROM SCHOOL TO HOME

The path having once been cleared before the nurse, she may go safely forward toward a general health campaign for children, conducted this time from the stronghold of the family, and reinforced by the ammunition of parental love and interest for the school child, as well as the extension of this same emotion to the other children in the same family. She may also use this entrance into one home as an introduction into neighboring homes in which there are children of preschool age, or infants under one year, and to those in which there are mothers treading the perilous pathway before the advent of their babies into the world.

THE TOLL OF CHILD-BEARING

Child health depends so largely on parental health that the care of the expectant mother should be considered the foundation of future health for the child. The nurse will need all the tact, influence, knowledge and persuasive power at her command. Because of natural reticence, the women who hesitate or refuse altogether to report their cases to physicians, sometimes are slow to tell even the nurses. Our Government, be it ever so paternalistic, has not yet required that the expectant mother shall register her hopes and her prospects with the State. Yet, in the world-wide campaign for a better race, this step would not be too drastic, considering the lack of knowledge which hundreds of thousands of mothers show during a time when they should be best informed as to the most hygienic rules—rules by which they may secure for themselves and

their offspring the only possible security for future health, usefulness, and even for life itself.

The world needs citizens who are physically fit; it needs women who are strong and well and able to bear healthy children. And in our widespread campaign to protect our citizens from the 630,000 needless deaths from preventable diseases which occur in a single year, we have not yet given to child bearing the consideration which it demands. While our death rate from tuberculosis has been reduced one-third; that from typhoid fever and diphtheria has been cut exactly in half, and that from smallpox has been reduced from ten per cent to one-half of one per cent, yet that from the so-called "natural function" of child bearing has been unchanged for a period of some twenty years. During the year 1919 it has been shown from carefully prepared statistics that five women out of every thousand die from some cause connected with child bearing. This, of course, means that our population has been reduced by just so much of this most valuable element; while in considering the deaths of children, it is alarming to remember that forty-five babies out of every thousand are still-born, and that in cases where no skilled care is given to the mother before or at the time of birth, forty out of those born alive die before they are one month old. On the other hand, when such care is given, the further statistics show that only two women instead of five die out of every thousand; that only twelve babies instead of forty-five are still-born, and that only ten instead of forty out of every thousand die under one month.

THE BATTLE CRY OF HEALTH

These figures are to the public health nurse a battle cry urging her on to service. Going into the home, seeing a pregnant woman, the whole picture of dire possibilities presents itself to her and at once she finds work for her busy hands to do and for active brain to outline and direct. Doctors there may be close at hand; how many women report to these doctors monthly during their period of pregnancy? How many have any idea that this should be done? How many have the proper care at the time of birth? The figures just given show that all too few have the faintest ideas as to the hygiene of pregnancy.

AS WOMAN TO WOMAN

The natural confidence of woman in woman gives the nurse an advantage in bringing about the needed care for the pregnant woman more effectually than can the health officer or the physician. Such care can be given only by medical skill, but the nurse can teach the mother to appreciate her need of medical care. The nurse can intelligently report on conditions. The prospective patient is usually willing to accept such service from the nurse when she could not be persuaded to go to a doctor in the beginning.

The nurse, having been of service to the mother before the birth

of her baby, is naturally the one whom the mother consults for advice on the care of the newborn baby. The bathing of the baby, the advantages of breast feeding, the directing of the preparation of artificial food where the physician indicates its necessity, all fall within the jurisdiction of the nurse, and by her untiring energy, interest and understanding, many small lives have been launched on the treacherous sea of life with an added measure of certainty that in time the port of adult health may be reached

THE HUDDERSFIELD PLAN

The nurse understands the value of preventive measures; she realizes the truth of the maxim that an "ounce of prevention is worth a pound of cure", and in order to procure this elusive "ounce", she works as hard to keep well babies well as she does to help sick babies get well. It would be a wonderful health measure if every county health officer, every physician and public health nurse, could employ the method once used by the Mayor of Huddersfield, England. So carefully were the little lives guarded and conserved that at the end of the first year the death rate was reduced in that town from 139 per thousand to only 44 per thousand, which has not yet been materially improved by our modern methods of baby saving.

THE LIVES OF BABIES SAVABLE

From the results of this method, developed more than twenty years ago, and from data steadily accumulated in this country since the New York City Department of Health established a Division of Child Hygiene in 1908, to the present day, it has been amply demonstrated that the lives of babies can be saved by judicious care, proper feeding, proper care of expectant mothers, and by those simple measures of hygiene which outrank all measures of medication in influence on the lives of babies. Hence it may be said with final authority that *keeping babies well* is one of the most important ways in which a public health nurse may cooperate with local health authorities, for with the baby kept well and given a fair start in life, the child of preschool, and of school, age, may be considered as equipped with a solid foundation of physical fitness. Building a sound structure on this foundation becomes a part of the nurse's work. She stands shoulder to shoulder with the health officer, and the pediatrist, in conducting nutrition clinics for malnourished children; in establishing Baby Health Centers for well babies, and baby clinics for sick babies. If a public health nurse has the highest ideals of service she will enter freely upon any program for promoting public welfare; but, being a woman, she will respond to the immemorial call of motherhood and lend herself with peculiar enthusiasm to every movement which tends to the protection of infancy, the conservation of maternity and to the positive promotion of child welfare.

Foods and Nutrition Committee

THE first meeting of the National Child Health Council's Advisory Committee on Foods and Nutrition was held in New York City June 4, 1921.

This Committee was formed because of the necessity for procuring a concensus of authoritative opinion regarding policies, methods, and standards which are essential to the effective conduct of nutrition work. Its recommendations should be useful not only to the constituent organizations of the National Child Health Council, but in connection with the proposed Child Health Demonstration, and to nutrition workers generally. Special significance will attach to its report on account of the different points of view represented by its members, twenty-seven in number. Some of these represent the medical profession, others the dietetians, the home economic teachers, social workers, food chemists, and physiologists. Seventeen of the members were present at this meeting and took active part in the discussion. Their entire willingness to attempt to reach agreement on debated points was most encouraging.

Dr. Joseph Goldberger of the U. S. Public Health Service was elected Chairman of the committee as a whole. The work of the four Sub-Committees and their personnel follow:

ORGANIZATION AND CONDUCT OF NUTRITION WORK

Miss Lucy Gillett was elected chairman of this Sub-Committee, which discussed the specific types of nutrition work which should be included in the general program for a well child; the contribution which may be made to nutrition work by public and private health agencies, social agencies, homes and schools; the best publicity methods to be used in reaching each of these groups; and the correlation of health and food agencies so that there may be no duplication or over-lapping of effort. It was decided that a program for the malnourished child would be prepared at once and should cover a recommendation for proper records for control groups, best ways of reaching the child and mother, and so forth.

Members of this Sub-Committee are: Mrs. Henrietta W. Calvin, Dr. Amy Daniels, Dr. Royal S. Haynes, Miss Mary G. McCormick, Dr. Mary Swartz Rose, Dr. Anna E. Rude, Miss Schermerhorn, Miss Anne Sutherland, Mrs. Ira Couch Wood.

TRAINING FOR NUTRITION WORKERS

Dr. Mary Swartz Rose was elected chairman of this Sub-Committee. This Committee realizes that in view of the very wide-spread interest in nutrition, as well as the quite general misapprehension of the subject upon the part of the

medical and nursing professions, social workers and others, it is well that some statement be made as to the nature and scope of the training which is essential in fitting one for doing nutrition work.

The Committee therefore offers the following recommendations:

I. As a preliminary to specialized training in nutrition, all candidates should have training in the fundamental sciences, physics, chemistry and biology.

II. The special training of nutrition workers should include:

(a) The subjects that contribute to the science of nutrition, e. g., physical and chemical physiology.

(b) The subjects which help to make practical the science of nutrition, e. g., dietetics and household management.

(c) Experience which gives insight into the medical and social problems of nutrition work, e. g., practical work in a medical social service clinic, to include social case work and record keeping.

III. In addition to the above essentials, training along the following lines is desirable:

(a) A knowledge of social agencies and their correlation.

(b) Training in the principles of education.

(c) Practical sociology and enconomics.

(d) Supervised practice in the nutrition field

(e) Training in bacteriology.

Members of this Sub-Committee are: Dr. Wm. R. P. Emerson, Miss Lucy Gillett, Dr. Samuel McC. Hamill, Dr. Lafayette B. Mendel, Dr. Agnes Fay Morgan, Miss Margaret Sawyer, Miss Ruth Wheeler.

FOOD REQUIREMENTS

Dr. John R. Murlin was elected chairman of this Sub-Committee which mapped out plans for the preparation, in popular form, of a statement regarding food requirements.

Members of this Sub-Committee are: Dr. Joseph Goldberger, Dr. H. R. M. Landis, Dr. C. F. Langworthy, Dr. Graham Lusk, Dr. Lafayette B. Mendel Dr. E. V. McCollum, Miss Lydia Roberts, Dr. Henry Sherman, Dr. Alonzo E. Taylor, Dr. Fritz Talbot.

MALNUTRITION

The Sub-Committee on malnutrition, after asking Dr. William R. P. Emerson to serve as chairman, agreed to formulate a statement regarding malnutrition as a prelimniary to further work.

Members of the Sub-Committee are: Dr. Joseph Goldberger, Dr. Lafayette B. Mendel, Dr. John R. Murlin, Miss Lydia Roberts, Dr. Anna E. Rude.

The Detroit Bureau of Wet-Nurses

Eleonore L. Hutzel, R. N., Director Social Service Department

Woman's Hospital and Infants' Home, Detroit

THE Detroit Bureau of Wet-Nurses is conducted as one of the activities of the Social Service Department of the Woman's Hospital and Infants' Home, Detroit, Mich. The Bureau was organized in 1914. Its purpose is to supply wet-nurses and mothers' milk to sick infants. The development of the Bureau has been the result of experiment and a response to actual community needs.

In every community there are women who cannot provide milk for their own babies. Certain of these infants can be adjusted to cows' milk formula and others cannot. In order to save the lives of the latter group, it is necessary that milk be obtained from nursing mothers who are able to supply more milk than their own babies require. When the need arises, this milk must be supplied immediately. The members of the Detroit Pediatric Society encountering this difficulty in their practice, set about to try to remedy it. Some of the members of the Society were also members of the staff of the Woman's Hospital and Infants' Home, a special obstetrical and gynecological hospital. The Board of Directors and the Medical Staff of the Hospital have for many years appreciated the value of mothers' milk, and have provided it for sick babies in the hospital. It was suggested that this service of the Hospital be extended so that in addition to providing mothers' milk for the babies in the Hospital, milk be supplied to sick babies in the community also. At a joint meeting of representatives from both organizations, the Detroit Bureau of Wet-Nurses was established.

GOVERNING BOARD

A simple constitution provides for an executive committee, to consist of three members appointed by the Detroit Pediatric Society and three members appointed by the Woman's Hospital and Infants' Home. The president of the Board of Directors of the Hospital and the chief of its medical service act as ex officio members of the committee. This group meets at regular intervals and directs the policies of the organization. The actual work of the Bureau is carried on under the supervision of the Director of Social Service of the Woman's Hospital and Infants' Home.

DEVELOPMENT OF THE WORK

During the first years of its existence, the Bureau was able to supply the physicians with wet-nurses and mothers' milk, and to continue to provide milk for the babies in

the Hospital. In 1914, mothers' milk was provided for 7 babies, and 32 wet-nurses were placed. In 1916, mothers' milk was provided for 158 babies, and 30 wet-nurses were placed. In 1920, only 4 wet-nurses were placed, while 43,802 ounces of milk were supplied to 227 babies. The furnishing of mothers' milk, by the ounce, has proven so entirely satisfactory that the demand for that service is constantly increasing, while the demand for wet-nurses in the home has become negligible.

By 1916 the increase in the demand for the services of the Bureau necessitated employing a nurse to take over a part of the work which until this time had been carried by the regular staff of the Social Service Department. In order to make permanent plans for the development of the Bureau, four weeks were spent in personally interviewing the physicians of the city and in visiting maternity homes and hospitals.

There were two definite results of this survey. First, it advertised the Bureau. Second, it provided those directing the work with definite information in regard to the probable demands for mothers' milk and wet nurses.

A year later, a second nurse was employed. The work was divided between the two nurses as follows: The first nurse was placed in charge of the wet-nurses in the institution and those coming in from outside for the purpose of expressing their milk. The second nurse made investigations and supervised the wet-nurses placed in homes in the community as well as those coming to the Hospital to supply the milk. The outside worker was provided with an automobile.

MEDICAL EXAMINATIONS

Both wet-nurse and patient are protected by medical examination. Each wet-nurse on application, is required to have a complete physical examination. A Wasserman blood examination is made and a cervical smear is taken. The baby of the wet-nurse is also given a thorough physical examination. Before a wet-nurse is placed in a home, a statement is required from the attending physician to the effect that there is no infectious disease in the home and that the patient shows no clinical symptoms of a venereal disease. A negative report on a Wasserman blood examination is also required from the patient. In cases where the condition of the patient is such that blood cannot be taken for examination, a second medical opinion is required. Both physicians must sign a statement to the effect that there is no evidence of infectious disease. The circumstances are then explained to the wet-nurse, and she is required to sign a statement releasing the Bureau and the patient's family from responsibility in case of infection. It is usual to supply such a case with mothers' milk rather than to furnish a wet-nurse.

A wet-nurse, when placed in a home, must have her own baby with her, and she must be nursing it. She is paid from twelve to sixteen dollars a week. The money is paid to the wet-nurse by the employer. The Bureau makes a charge to the employer of ten dollars for registration, and of fifty cents a visit for the supervision of the wet-nurse. While on duty, the wet-nurse wears a uniform supplied by the Bureau, but paid for by the wet-nurse. The wet-nurse cares for her own child and for the infant she is nursing. She washes the nursery flannels and cares for the nursery, but is not permitted to do any additional work. The Bureau requires that each wet-nurse be out of doors and away from the patient at least two hours each day. Hours of feeding must be regulated so as not to be harmful to the wet-nurse, and to allow her time for necessary sleep.

The wet-nurse and her baby are carefully supervised to see that they remain in good physical condition. This phase of the work has been found to be very difficult. The home of the parents of the sick child is often small so that it requires much adjustment to make room for a wet-nurse and her baby. The necessity of preparing meals for an extra person is an additional burden for a mother nervous and worn out from anxiety and lack of sleep. The wet-nurse, often a young, untrained girl, incapable of appreciating the mental condition of the baby's mother, is quick to resent criticism and inclined to overestimate her own service. A new wet-nurse in a home where the circumstances are difficult, needs daily supervision. Usually the first week is the most trying to the family and to the wet-nurse. After that, if the patient is improving, two supervision visits a week are sufficient, and later, one visit and one telephone call a week.

MOTHERS' MILK BY THE OUNCE

This department of the work has developed very greatly. The milk is supplied by women who reside in the community and come to the Hospital daily to express their milk, and by women who live in the institution. No woman is permitted to furnish milk unless she is nursing her own baby, if the infant is under ten months of age. At that age, the wet-nurses are allowed to wean their infants. They may continue to supply milk to the Bureau as long as the quantity is adequate and the quality is satisfactory. The quality of the milk is determined by laboratory examination. The milk is supplied to patients only on a doctor's prescription. No deliveries are made, but an iced container is provided for carrying the milk, the purchaser being required to pay for the container. The money is refunded when the container is returned. All milk is expressed with the fingers. This method of expressing milk is very satisfactory. Breast pumps are never used, and no wet-nurse employed by the Bureau has ever had a breast abscess. Certain

women who have been under the supervision of the Bureau for a considerable period and who are known to be reliable, are permitted to express the milk in their own homes, and to bring it to the Hospital. The nurse keeps these women under close supervision, visiting them at the time when they are expressing the milk, if possible. A sterile bottle, a cup, and a funnel are provided every day to each of these women. The Bureau pays ten cents an ounce for this milk, and gives carfare. A wet-nurse who lives in the institution and supplies twelve ounces of milk or less a day, is paid six dollars a week with maintenance for herself and her child. If she supplies more than twelve ounces a day, she is paid five cents for each additional ounce. It is estimated that the average cost of production of mothers' milk is twenty-one cents an ounce. The patients are charged according to a sliding scale. Institutions and social agencies, fifteen cents an ounce, and private individuals from fifteen to twenty cents an ounce. Milk is supplied at any time free of charge to any infant needing it, whose parents are unable to pay. The resulting deficit is made up by the Detroit Community Fund.

The most serious problem connected with the work and one which must be met each day is caused by the fact that the demand for mothers' milk and the supply are so uncertain. This has resulted in the Detroit Bureau of Wet-Nurses making a rule that it must be given twenty-four hours notice of any change in an order. It is necessary that some place be available where surplus milk can be used, and that there be some way of meeting emergency calls. The Detroit Bureau of Wet-Nurses sends its surplus milk to local hospitals where sick children are cared for. No charge is made for this milk. In an emergency, when no milk is available from the regular supply, the dependent mothers who are being cared for in the Social Service Department, are asked to supply the few necessary ounces, giving their own healthy babies one or two feedings of formula for a few days.

It is essential that a wet-nursing bureau have an income other than that derived from the sale of milk. The workers must be free to make plans which will result in the greatest possible good to the patient, and this can be accomplished only when they are free from the necessity of collecting a certain amount of money each month.

Certain interesting experiments dealing with the production of human milk, especially as related to the diet, have been made by the physicians interested in the Bureau. Results of these experiments have been published, and the Detroit Bureau of Wet-Nurses, Woman's Hospital and Infants' Home, 145 Forest Avenue East, Detroit, Michigan, will furnish copies to any one who is interested.

MOTHER AND CHILD
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JULY, 1921

Milk and Morale

THE great military genius who made the observation that "an army fights on its stomach", may have coined a better, but never a more widely quoted epigram. Though it is less dramatic, it is no less true, to say that "a nation grows on its cows." The role of clean milk in the dietary of the growing child, or as a supplement to breast feeding in the infant, is assuming more and more importance, as time goes on, and as investigators study the underlying causes of many of the disorders of nutrition. Not only as a simple food, but especially because of its richness in those accessory food principles vaguely known as vitamines, which are essential to a well balanced dietary, the question of an abundant and clean milk supply is becoming as important a social and economic factor as the balance of export trade, the rate of exchange, or other institutions of the kind, which we can feel, but cannot understand.

For example, S. G. Moore, M. D., D. P. H., Medical Officer of Health in the English town of Huddersfield, writes in the March number of *National Health,* concerning the dangers of impure milk and the problem of safeguarding a pure supply. He points to the enforcement of compulsory pasteurization in the United States as a happy solution to the vexed problem, and asks that, in the interests of public health, similar measures be adopted in England.

How interest in the milk problem is growing in England is evidenced by frequent comment not only in health magazines, but in the daily press as well. Thus, the authoritative *Manchester Guardian,* in its issue of April 2, says:

"There is a growing interest in London in the subject of milk consumption. The report of Lord Astor's committee made it clear that Londoners drink only one-third of the amount of milk consumed per head in New York, and that the value of milk, especially as food for children, has not been realized. A campaign for persuading the public to drink more milk is being initiated by the milk producers and distributers, a campaign which may unfortunately be discounted by the fact that larger consumption of milk means increased profits."

It may encourage our English friends to learn that in spite of the large per capita consumption of milk in the United States, dealers here are only beginning to realize the practical value of ethical advertising in popularizing milk as a food, and some are now advertising their products on the basis of the very standards they once antagonized.

The observation, well borne out by history, that when food is scarce and expensive the child always suffers, was corroborated by the investigations of the Children's Bureau of the United States Department of Labor, which found a greatly decreased use of milk in feeding our children during the period of high prices which prevailed in 1918. Medical authorities in England are well aware of this economic phenomenon and are alarmed at the prospect of a child population raised on an insufficient milk ration and the March issue of the *Medical Officer* (London) says:

"The Ministry of Health has estimated that the amount of liquid milk available for the whole country, in January and February, was roughly a quarter of a pint a day per person. This amount is supplemented with condensed milk. It is reasonable to assume that many children do not get fresh milk at all, especially as the quantity of milk used by the poor is also regulated in large measure by the ability to pay for it."

Nor is the fear of the effects of a milk shortage confined to those European countries which were engaged in the World War. A correspondent of the *Journal of the American Medical Association,* writing from Holland, in the issue of April 16, says:

"To prevent a shortage of milk and milk product supplies, due to the increasing demand for them for home consumption and excessive sales to Germany, the Dutch government recently established a dairy bureau under the direction of the Ministry of Agriculture, to control the production of butter, cheese, and so forth, and regulate the distribution of sweet milk throughout the country. The Bureau is supported by a tax on milk production. It controls distribution by purchasing the sweet milk and reselling it to the dealers."

This is additional evidence of the growing importance of milk as a food. Let us, therefore, not pass over our abundant milk supply in computing our national wealth—this is a land flowing with milk and honey—or at least molasses.

It will be recalled that the Egyptians venerated a cow-goddess which they called Hathor. The growing reverence for the erstwhile humble bossie which seems to be assuming international proportions, is only another indication that the Egyptians of ancient days were full of knowledge.

John Foote, M. D.

The Day's Work

THE NEED OF HEALTH DIRECTION

DR. FLORENCE A. SHERMAN, Assistant Medical Inspector of the State Department of Education, New York, writing to Mother and Child, tells of a survey made of a group of fourth and fifth grade school children in a Long Island school, with special regard to nutrition, but including contributing factors.

Sixty-one children were stripped to the waist, and the shoes and stockings were removed. Careful attention was given to the the weights and measures and postural conditions. A careful examination of the heart and lungs was made.

Analysis of the cases shows the following findings as to pupils who were below normal weight: ten, one pound; four, two pounds; five, three pounds; three, four pounds; nine, five pounds; four, six pounds; one, seven pounds; one, eight pounds; six, nine pounds; five, ten pounds; three, eleven pounds; one, twelve pounds; one, thirteen pounds; one, seventeen pounds; and one, twenty pounds. Five pupils were found to be over weight, and one was normal.

The postural findings showed one child to be posturally and physically normal; fifty-seven had poor posture, round shoulders and bat winged shoulder blades; three had spinal curvatures; four had flat foot; and four, weakened arches.

The other findings were: sixteen pupils, enlarged tonsils and adenoids; two, marked anaemia; forty-five, defective teeth; four, defective vision; four, blepharitis; three, heart murmurs; one, strabismus; one, absent uvula; one, chorea; and one had a paralyzed right arm.

All the pupils but one were below par in nutrition, and needed careful individual health direction as to daily habits, rest, recreation, posture, and breathing.

Dr. Sherman says:

"This survey emphasizes particularly the importance of the correction of the various physical defects noted which without doubt acted as large contributing factors to nutritional findings. I think this point should be strongly emphasized in order to make this feature of our health work bring about the desired results. It is safe to say that this survey shows the typical conditions of the children in the grades who were not examined at this special time."

FIELD DIRECTOR'S WORK

Miss Harriet Leete, Field Director of the Association, has recently returned from visiting some of the Affiliated Societies in Toronto, Montreal, and in New England. The Executive Committee were greatly impressed with the report of this work presented by Miss

Leete, which the Chairman characterized as being "the most important work undertaken by the Association this year".

Early in June Miss Leete left to carry on the same work in Chicago, Minneapolis, Helena, Spokane, and Seattle.

From the nineteenth of June to the thirtieth of July, she will give a course of lectures on child hygiene in the University of Oregon.

WHY STATISTICS?

In another part of this magazine will be found a brief analysis of the Report of Infant Mortality for 1920 in 519 Cities of the United States just published by the American Child Hygiene Association. The Association is not interested in statistics except as they may be of practical value in the work for better, healthier babies, and statistics of Infant Mortality are our most valuable method of checking up our success or failure. Appearing as it does at least six months before the Census Bureau can study and tabulate the individual certificates and publish its valuable report, makes it all the more useful.

As is stated in the article mentioned, the fact that our Infant Mortality Rate has fallen ten points in five years, instead of giving us an excuse to lie down on our job, should only urge us forward to further efforts. It is a question of education, health education, and money spent in the prevention of disease and death is wisely spent. Economy in that direction is extravagant economy. We may well adapt the warning to the Roman Senate, "Let the Legislators see to it that the Babies suffer no harm".

THE NATIONAL HEALTH COUNCIL

The National Health Council is issuing bi-weekly summaries of National health legislation. These reports give a resume of progress on bills which have previously been reported, and also list and abstract all new legislation relating to health. This service was inaugurated at the beginning of the present session of Congress and will continue through future sessions. The reports are prepared in the Washington office of the Council.

They are mimeographed and vary in size from eight to twenty pages. They are distributed to members of the Council, and also at cost price to non-members who have requested them. About 250 persons are now on the mailing list. An extension of this valuable service to cover state legislation is planned.

The National Health Council has extended its information service by assembling information for government officials with reference to federal health reorganization. A booklet giving complete data on each of the ten member organizations of the Council has been published.

A monthly news letter is now being circulated among the members of the Council. This news

letter contains information regarding the work of each member during the month, proposed undertakings, personal items, new publications, and similar material.

For the first time in the history of public health, the offices of a number of national voluntary agencies are now in one building. The National Health Council, working with a Common Service Committee, has been instrumental in bringing together the following health agencies, in the New Penn Terminal Building, opposite the Pennsylvania Station in New York City:

The American Public Health Association; American Social Hygiene Association; Bureau of Social Hygiene and Committee on Drug Addictions; Child Health Organization of America; Maternity Center Association; National Committee for Mental Hygiene; National Organization for Public Health Nursing (with the American Nurses' Association and the League for Nursing Education); National Tuberculosis Association; New York Community Service; New York Diet Kitchen Association, The Committee to Study Community Organization, the National Health Council, and the Common Service Committee.

While zealously preserving the autonomy of each participating agency, the Common Service Committee plans to offer certain optional common services. These include general accounting, centralized telephone service, a joint library conference and rest rooms, and the pooling of mailing and various other office administrative functions which, if done separately would be less efficient and more expensive.

PUBLIC HEALTH NURSING IN PITTSBURGH

Miss Nan L. Dorsey, R. N., Director of The Public Health Nursing Association of Pittsburgh, says:

"The Public Health Nursing Association of Pittsburgh, is established on the basis of generalization, including on the staff of executives, specialists who are engaged as instructors and advisors for the field workers.

"Through affiliation with the Tuberculosis League the Association has the benefit of instruction and advice from a nurse who is trained and had had long experience in Tuberculosis work. A series of lectures is given to each individual group in the Substations. Much better results can be secured, and much more intimate discussion can be brought about, when special lectures are given to the smaller groups, rather than to the whole staff. Individual families of each district can be brought up in a detailed way, and puzzling situations worked out right there at the Substation, and home visits made if necessary. The Association is exceptionally fortunate in having the cooperation and assistance of Miss Alice E. Stewart, Superintendent of the Tuberculosis League of Pittsburgh. Miss Stewart makes

continuous rounds of the Substations.

"The Association is now planning the same thing for Infant Welfare and Pre-school children. The Association will be just two years old July 1st, 1921. Up to this time it has been necessary to devote all the time to the organization of the existing factors. Now it is prepared to enter vigorously the field of Child Welfare. The first move was to secure a nurse who was a trained Child Welfare consultant and instructor—Miss Helen A Bigelow. Miss Bigelow began her work with the Association June 15th, 1921.

"Miss Bigelow will instruct each group at the Substations, making visits with the nurses on the child welfare problems, teaching them how to teach in the homes. This first summer there will be established four well-children's clinics, children from infancy to school age. These clinics will be held in the same substations as the maternity clinics which are already established.

"A nucleus of these clinics has been awaiting Miss Bigelow's coming. We hope through the coordinated services into which Pittsburgh has so heartily entered, we shall in the very near future show a very different record both in morbidity and mortality rates. In addition we hope this experiment of complete generalization will prove to be a practical plan that will give the desired result which is better health teaching by better health teachers entering many more hundreds of homes, with more comprehensive knowledge of a whole situation rather than any one part of it."

MILK IN SCHOOLS

Dr. J. W. Brewer, Health Officer of Watertown, New York, writes as follows:

"Recess lunches of pasteurized milk are now being furnished in most of the schools in the city of Watertown.

"In March, 1921, a parent teachers association was formed in the Arsenal street school, and at that time Miss Mary Lawyer, the principal of the school, recommended that milk be furnished for the undernourished children. A collection was taken up and funds provided for a start. She began with 12 half pint bottles. The drinking of milk has become so popular that over 150 bottles are now being furnished. In most instances the children pay for the milk, but those who can not afford to are furnished free. From this beginning the furnishing of milk has been taken up by the other schools. This is entirely a voluntary movement and is selfsupporting.

CHILD HYGIENE IN SUMMER SCHOOLS

Two courses on the family, to be given by Dr. Dorothy Reed Mendenhall, are offered by the University of Wisconsin summer school—the mother and child, and the care

and feeding of the older child. The courses are especially designed for experienced teachers, for prospective home demonstration agents, and for nutrition specialists. (Journal of Home Economics, April, 1921.)

An intensive course in child hygiene and nutrition was given at the School of Public Health, Louisville, Kentucky, June 6-18, under the direction of the State Board of Health. The course was intended primarily for physicians, nurses, social workers, teachers, home economics workers, and club women.

A course in maternal and infant hygiene is offered by the summer school of the University of Alabama. The course aims to give "a comprehensive view of the maternity and infant death rate, with enough detail as to cause to suggest appropriate remedial measures". This course is intended primarily for home demonstration agents, social workers, and teachers of hygiene. (Bulletin of University of Alabama, March, 1921.)

CREDITS FOR HEALTH HABITS

Ratings in health habits and citizenship are given school children of Binghamton, New York, in their quarterly reports. Each subject covers a page of the report. Health Habits covers neatness of dress and person, care of books, posture, class work in hygiene, height, weight, etc., while citizenship includes such subjects as manners, obedience, and respect for property. (School Life, April 15, 1921.)

NEW JERSEY ENTERS BIRTH REGISTRATION AREA

The admission of New Jersey to the United States birth registration area has just been announced by the State Bureau of Vital Statistics. The registration area comprises all States in which it has been proved that 90 per cent of all the births occurring in the State are properly recorded. The tests of the Federal Government indicate that 95 per cent of the births in New Jersey are now so recorded. (Newark News, April 27, 1921.)

OUTDOOR BABY WARD

An outdoor ward for babies has been maintained for a number of summers by the Babies' Hospital of Cleveland. It will be opened this summer July 1, and only children who are acutely ill will be received for care. (Public Health Nurse, May, 1921.)

SAVING BABIES' LIVES

The infant mortality rate in Greater New York, for the first fourteen weeks of 1921, is reported to be 80, as against 112 for the corresponding period last year. This is the lowest figure recorded within the last twelve years. The mild winter may be in part responsible for the low rate, but it is evident that the general public is becoming educated to the importance of cleanliness and child hygiene. (Brooklyn Standard Union, May 6, 1921.)

The Foreign Field

The Hospital (Innocenti) of Florence, which, until fifty years ago, received foundlings placed in the swinging cradle in its wall. Lamartine said of this cradle that it had neither eyes to see, nor ears to hear; only arms to receive the baby.

Italy's Care of Children

Gina Fodda, Director of the Course in Public Health Nursing in Rome

[Note—Miss Fodda is an Italian Red Cross nurse who has been decorated several times for her excellent service in military hospitals. She was a pupil of the first American Red Cross course in Public Health Nursing, given in Rome in 1920. She has helped organize some of the courses in training in Trieste and Turin.)

ALL lovers of Italy who come from every part of the world to study and admire the traces of one of the most ancient and perfectly civilized races of the world, and who are well acquainted with the remaining monuments of Rome, have certainly noticed that betwixt all that was made to glorify warriors and adorn towns, the Romans did not forget to have buildings purposely made for inspiring love of physical culture, which was as much appreciated as well-developed and cultivated minds. The large public baths, the arenas where athletes formed the principal attraction, the statues which today still stand to challenge our imagination of the beautiful body of the gladi-

ators and discoboli, suffice to prove that physical culture was far from being an unimportant subject in the glorious days of Rome.

Things have unfortunately changed a great deal since then; the continual struggles of which Italy, before its unity, has been the theater for centuries; the numerous armies, rulers and laws which contended for its fertile soil; and finally the effort which united people and government in acquiring the long aspired for independence, absorbed every energy and every thought.

As soon as the conditions of the country rendered it possible, our medical men and philanthropists gave their attention and riveted their energies towards bettering the neglected public health conditions, and gave special importance to the hygienic protection of infancy.

Professor Concetti, of the Roman University, created the first pediatric school in Italy in 1882. This meant great progress, because it brought together a group of medical men, devoting special care and attention to childhood. They studied the various ailments and succeeded in reducing infantile mortality from 35 per cent to 12 per cent. During the war infantile mortality did not increase as much as it did in other countries. In many parts of Italy, with the help of the government and of private institutions,* clinics, hospitals, feeding kitchens for nursing mothers, dispensary services and clinics were founded to the great benefit of new-born and ailing children.

In the space of a few years, several institutions for nursing mothers and children, some beginning very modestly through a generous gift, and the help of volunteer workers, were founded and prospered, thus completing the work done by the government for the diffusion of knowledge regarding childhood—for the bettering of the race. In many large and small towns of Italy we now have maternity rooms with annexed dispensary service, kitchens for nursing mothers, infant welfare conferences for children in the first year of life. Italy has some open-air schools, some Alpine and sea colonies, for the ailing ones, and similar organizations, still on a

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*Genoa has an unusual Preventorium up in the Alps for the children of tuberculous parents. The government does not compel hospitalization, consequently a private tuberculosis association has established this beautiful home, where these children are kept for months at a time.

The open air school in Genoa is one of the best I have ever seen and ones in Florence and in Rome are excellent.

I have never been in a country where everyone seemed more thoughtful of, kind to, and fond of children. In fact, the busiest and most celebrated physicians think nothing of giving hours of their time to the free clinics of some of the large dispensaries.—*Edna L. Foley.*

modest scale and not sufficient in number. Over 3,000 new organizations for child welfare have been founded in Italy during the war, and nearly all are still working, helping the expectant mothers, the well and sick babies, and the children of school age. This is the best proof of the growing interest of Italy in hygiene and public health work.

The long flowing dress covers the tight swaddling bands of the baby, who is awaiting the opening of the clinic in the hill town of Sezzi.

In the last few years the organization of visiting nurses has come to contribute to the development of the already existing institutions. In the populated and poor centers where they have begun to work regularly, our nurses have become welcome friends and advisers of the poor, especially of the mothers and children; they have been received everywhere with faith and gratitude. Their mission consists not only in nursing the sick, but in helping the women with the care of children, and bringing in the place of old prejudices still remaining from the time of slavery, and disorderly habits, the words of modern sanitary and hygienic systems. This useful and far-reaching organization is entirely owing to the indefatigable and competent help of three American women, Miss Gardner, Miss Thompson and Miss Foley, belonging to the American Red Cross,* who came to Italy during the war and founded the first school for public health visiting nurses, and organized the service in three

*Aided by several American Red Cross Public Health Nurses, who made possible the success of the undertaking.

large centers. Following the way traced by them, we are now enlarging this organization and have good hopes of seeing it extend all through Italy with great benefit to the poor as well as enlightening the work of both hospitals and dispensaries.

In the centers where visiting by the nurse is regularly practiced we have succeeded in persuading the women to give up two very ancient and firmly established habits: first of all, swaddling the infant with stiff bandages which render every movement impossible; second, persuading them of the many dangers of having a baby sleep in the bed with the mother and father. Dissuading them was no easy task. The elder women boasted that in their way generations of strong children have been reared. Only the sympathy personally felt for the visiting nurse, the advantages found in her help and in the following of her practical advice, gradually brought the most obstinate and ignorant people to the observance of the rules that modern pediatric science has established for the care of infancy.

To give a still wider diffusion of hygienic principles, and to teach the elements of the care of children to the largest possible number of women, courses of special lectures were instituted in girls' high schools and especially in those for teachers, because the school mistress, who is in constant contact with the parents of the children entrusted to her, is the best of agents for bringing hygienic notions to families in every social condition. These lectures are given by country school teachers also, and have not small importance, for in small and isolated centers, far from doctor and midwife, the teacher is often called upon to help and comfort.

In the last two years popular lectures have been given by specialized doctors in some cities to teach general hygienic principles, especially the care of children. These lectures, which take place in very poor and populous quarters of our large towns, as well as in factories where women work, are followed diligently by the women of the people who often at the end of the lecture ask for further advice and instruction, showing special interest in the rearing and care of children.

Two things in Italy are a great help in making the children healthy: first, the mothers in every social class nurse their infants; a healthy woman feels that giving up the feeding of her offspring is humiliating to herself, and if she is not in condition to do so, she regards it as a great misfortune; second, the mild climate and the bright sun make it possible for the children to pass the greater part of their lives in the open air. It is thanks to the climate that many epidemics and acute ailments are avoided or easily overcome among the poor and badly cared for children.

On two things Italy can found her hope for the future: the fertile

soil and the fact that the number of births is greater than the number of deaths. To these children who are to be the strength and power of the morrow, we must give our thoughts and energy so that they may grow up strong and healthy for themselves and for the Nation.

Recent Literature on Mother and Child Welfare

In place of the usual Book Review and Bibliography, there is given here a special list useful in Nutrition Work, prepared by the Dietetic Bureau of Boston*

Books, Pamphlets, and Magazine Articles

A Child's Book of the Teeth. H. W. Ferguson, D. D. S. The author has set forth a few facts of a scientific subject in a simple and interesting manner that the book may be attractive to the child and be understood by him. 52c. World Book Company, Yonkers-on-Hudson, New York, 1918.

A City of Good Neighbors. Miss Mary S. Haviland. Community Hygiene for children 11 to 15 years. Lippincott & Co., Philadelphia. In preparation.

Bodily Mechanics: Its Relation to Nutritional Disorders. Lloyd L. Brown, M. D. The Commonhealth, July-August, 1920. Massachusetts Department of Public Health, Boston.

Care and Feeding of Children. Emmett L. Holt, M. D. A consideration of the needs of the well child. $1.25. D. Appleton and Co., New York, 1920.

Child Care. Mrs. Max West. Part I. The Pre-school Age. Directions for care and hygiene. 20c per copy. Superintendent of Documents. Government Printing Office, Washington,D. C., 1918.

Defective Nutrition and Growth. Frank A. Manny. A Selected Bibliography. 10c a single copy. Nutrition Clinics for Delicate Children, 44 Dwight St., Boston.

Dietetics for High Schools. Florence Willard and Lucy H. Gillett. To teach the applications of the principles of nutrition to the feeding of the family. $1.50. Macmillan Company, Boston, New York. 1920.

Feeding the Family. Mary S. Rose. A guidebook to good nutrition of different members of a typical family group and the group as a whole. $2.10. Macmillan Company, Boston, New York. 1916.

First Reader, Nutrition Series. Anna R. Van Meter. To introduce right habits of food and diet along with the business of learning to read. Merrill-Palmer Motherhood and Home Training School, 301 Palmer Building, Detroit. 1921.

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*A further list of suggestive Outlines for Nutrition work; Reports of Nutrition work with Children; Pageants and Plays; Stories; and Songs can be had by addressing the Dietetic Bureau, 376 Boylston Street, Boston.

Food Allowances for Healthy Children. Lucy H. Gillett. A survey of evidence regarding food allowances for healthy children. 10c a copy. Association for Improving the Condition of the Poor, 105 E. 22nd St., New York City. 1917.

Food for Children from Two to Six. Richard M. Smith, M. D. Reprinted from Public Health Bulletin of the State Department of Health, Vol. 5, No. 2, 1918, Boston, Mass.

Food for School Boys and Girls. Mary S. Rose. 10c a copy. Bureau of Publications, Teachers' College, Columbia University, New York. 1914.

Food for School Boys and Girls. A leaflet with menus. 60c per 100, $5 per 1000. New England Dairy and Food Council, 51 Cornhill, Boston, Mass. 1921.

Food for the Family. Suggests such meals as will be best for growing children. 5c per copy. Association for Improving the Condition of the Poor, 105 E. 22nd St., New York City. 1917.

Food for Young Children. Caroline L. Hunt. Farmers' Bulletin, 717. Free. U S. Department of Agriculture, Washington, D. C. Revised. 1920.

Food Primer for the Home. Lucy H. Gillett. Based upon results of 3 years' research reducing the food problem to simple graphic terms that can be easily understood. 20c each. Bureau of Foods Supply, A. I. C. P., 105 E. 22nd St., New York City. 1918.

Health Chart Booklet. Thomas D. Wood, M. D. Describes 58 health charts in miniature. 25c. National Council of Education, 525 W. 125th St., New York City.

Health Crusade Material. National Tuberculosis Association. Tells how to organize a Health Crusade. Free. National Tuberculosis Association, 381 4th Avenue, New York City.

Health Education Publications, printed by the Government Printing Office:

Wanted! Teachers to Enlist for Health Service. Lucy Oppen. Single copy 5c; additional copies 1c each. Superintendent of Documents, Government Printing Office, Washington, D. C. 1919.

Class Room Weight Record. Ditto price. Ditto publisher.

Diet for the School Child. Lucy H. Gillett. Proper feeding is one of the chief factors in health. Single copy 5c; additional copies 2c each. Ditto publisher, 1919.

Summer Health and Play School. The open door to health for city children. Ditto price. Ditto publisher, 1919.

Teaching Health. Lucy Oppen. Make health habits automatic in youth. Ditto price. Ditto publisher, 1919.

Further Steps in Health Teaching. Lucy Oppen. For the teacher who has weighed and measured her pupils, and who writes, "What shall I do next?" Ditto publisher, 1920.

The Lunch Hour at School. Katherine A. Fisher. A survey of school lunches in various parts of the country was made and much of the information is included. Single copy 5c; additional copies 4c each. Ditto publisher, 1920.

Health Training for Teachers. Robert G. Leavitt, Ph. D. The Role of Normal and Training Schools in the advancement of health education. Single copy 5c; additional copies 4c each. Ditto publisher, 1920.

Health Teaching in the Schools. L. Emmett Holt, M. D. Single copy 5c; additional copies 3c each. Ditto publisher, 1921.

A Program for Health Teaching. J. Mace Andress and Mabel Bragg. Ditto, 1921.

Health Education in Rural Schools. J. Mace Andress. $2.00. Houghton, Mifflin, Boston.

Health Essentials for Rural School Children. Thomas D. Wood, M. D. An excellent brief outline as applicable to city conditions as to rural. 10c each; $5 per 100. American Medical Association Press, 535 N. Dearborn St. Chicago.

Health in Play. An 8-page booklet to assist in organizing health activities on the playground. 6c each; $5 per 100 Child Health Organization, 370 7th Avenue, New York City. 1921.

Health Pamphlets. A series of pamphlets designed to point the true way to health and happiness. 5c each; 25c per set of six; $20 per 100 sets. Woman's Press, 600 Lexington Avenue, New York City.

Home Care of the Mouth. Free Metropolitan Life Insurance Co.

Milk. Numerous leaflets and pamphlets with illustrations. Free in the state. Massachusetts State Department of Agriculture, Dairy Division, 136 State House, Boston.

Milk—The Best Food We Have. U. S. Food Leaflet No. 11. Free. Department of Agriculture, Washington, D. C.

Milk, the Indispensable Food for Children. Dr. Dorothy R. Mendenhall. Free. Children's Bureau, Washington, D. C.

Milk—The Master Builder. Useful as a basis for plays, stories and rhymes. $1.00 per 100; $9.50 per 1000. Child Health Organization, 370 Seventh Avenue, New York City.

Milk — The Necessary Food for Growth and Health. Dr. Elmer V. McCollum. Address before the National Dairy Conference, Chicago. 2½c each, per 100 lot. National Dairy Council, 910 S. Michigan Avenue, Chicago. 1918.

Minimum Health Requirement for Rural Schools Thomas D. Wood, M. D. Useful for the city as well as the country teacher. 5c each; $3 per 100. American Medical Association Press, 535 N. Dearborn St., Chicago, Ill. 1920.

Minimum Standards for Child Welfare. Thomas D. Wood, M. D. Adopted by the Children's Bureau Conference on Child Welfare Standards. Free. Children's Bureau, U. S. Department of Labor, Washington, D. C. 1920.

Origin of the Modern Health Crusade. Red Cross Magazine. September, 1919.

Posture Clinics Established by a School Nurse. Isabel Durgan, R. N. An account of postural corrective work carried on in the public schools of Winthrop, Mass. The Commonhealth, March, 1920, Massachusetts Department of Public Health, Boston.

Posture of School Children. Jessie H. Bancroft. $2.00. Macmillan & Co., Boston and New York.

Practical Mental Examinations for Growing Children. A. Warren Stearns, M. D. 10c a single copy. Nutrition Clinics for Delicate Children, 44 Dwight St., Boston, Mass.

Primer of Hygiene. John W. Ritchie, Joseph S. Caldwell. A simple text book on personal health and how to keep it. 88c. World Book Co., Yonkers-on-Hudson, New York. 1920 Revision.

Primer of Sanitation. John W. Ritchie. On disease germs and how to fight them. $1.00. Ditto Publisher.

Primer of Physiology. John W. Ritchie. Practical text on the physiological principles and their application to problems of health. $1.12. Ditto publisher.

Primer of Sanitation and Hygiene. John W. Ritchie. $1.60. Ditto publisher.

Recent Developments in Child Feeding. Mary Swartz Rose. Presented at Home Economics Conference, Michigan Agricultural College. 15c. Reprinted from Teachers' College Record, Vol. XVI, November, 1920. 1920.

Reprints from Woman's Home Companion. W. R. P. Emerson, M. D. A series of articles on the underweight child and general health problems for children. 24c per set of 12. Woman's Home Companion, 381 4th Avenue, New York City, August, 1919, to July, 1920.

Silent Reading for Health (Primer). (1) To aid the formation of health habits. (2) To encourage original thought. 7c each, $6.50 per 100. Iowa Tuberculosis Association, Des Moines. 1919.

Teaching Hygiene in the Grades. J. Mace Andress. Practical suggestions for teachers on teaching hygiene in the grades. 75c. Houghton, Mifflin Co., Boston. 1918.

The Food Requirements of Children. Holt and Fales. Total caloric requirements. American Journal Diseases of Children. Vol. 21. January, 1921.

The Most Wonderful House in the World. Mary S. Haviland. Personal Hygiene for Children from 8 to 11. 80c. J. B. Lippincott Co., Philadelphia. 1921.

The Newer Knowledge of Nutrition. E. V. McCollum. The use of foods for the preservation of vitality and health. $1.25. Macmillan Company, Boston, New York. 1919.

The Physical and Mental Defects of So-Called Well Children. W. R. P. Emerson, M. D. 10c a single copy. Nutrition Clinics for Delicate Children, 44 Dwight St., Boston.

The Play-House. Mary S. Haviland, Home Hygiene for Children from 8 to 11. 88c. J. B. Lippincott Co., Philadelphia. 1921.

The Right Food for the Growing Child. Very practical outline for child feeding. 5c each. Minnesota Public Health, 300 Shubert Building, St. Paul. 1921.

The Well Baby Primer. Caroline Hedger, M. D. Is designed to be of service in the Americanization program. 15c each; 10c per 100 copies; 8c each per 500 copies. Elizabeth McCormick Memorial Fund, 843 N. Dearborn St., Chicago.

The Worker's Tool Chest. Mary S. Haviland. Pre-Vocational Hygiene for Children from 11 to 15. Lippincott & Co., Philadelphia. In preparation.

Twelve Chapters in Hygiene. Dr. George M. Kober. Each chapter corresponds with the Health Jingles in "Strike for Health." 15c. Jim Publication Co., Washington, D. C. 1919.

Weight and Height in Relation to Malnutrition. W. R. P. Emerson, M. D., Frank A. Manny. 10c. Nutrition Clinics for Delicate Children, 44 Dwight St., Boston. 1920.

What Is Malnutrition? Lydia Roberts. A statement of the extent, symptoms and causes of malnutrition. Free. Children's Bureau, U. S. Department of Labor, Washington, D. C. 1919.

What Milk Will Do For Your Child. Elizabeth McCormick Memorial Fund, Chicago. A well illustrated pamphlet on milk. 2½c each per 100 lot. National Dairy Council, 910 S. Michigan Avenue, Chicago.

Posters, Charts, and Records

Babes in Healthland. Anti-tuberculosis posters for children. 8 panels, $7, 17x28 in. National Child Welfare Association, 70 Fifth Avenue, New York City.

Cho-Cho, the Health Clown. A brightly colored picture of Cho-Cho. Compliments of Colgate Company. Child Health Organization, 370 7th Avenue, New York City.

Cho-Cho Says (Poster). Chart 20x 28½ inches. Printed in blue on orange background. 25c single copy; $20 per 100; $160 per 1000. Ditto publisher.

Chore Pictures. Attractive pictures in blue, white and black illustrating the Health Crusade Chores. 11c per set of 12. $10 per 100. Iowa Tuberculosis Association, 518 Century Building, Des Moines.

Corrective Exercise Cards. Twenty-two pen and ink accurate illustrations with detailed instructions. 10c per set of 22; 65c per dozen sets; $5 per 100. Woman's Press, 600 Lexington Avenue, New York City.

Food Charts for Exhibition Purposes Lucy H. Gillett. Set of 9, 22x28 inches, including book, "The Adequacy and Economy of Some City Dietaries." $2.50. Bureau of Food Supply, A. I. C. P., 105 E. 22nd St., New York City.

Food Charts. Lucy H. Gillett. Photographic set of 9, size 5x7 (for carrying). $1.00. Ditto publisher.

Foods and Health. Presents classes of foods needed for a well-balanced diet. 10 panels, $8.00. 17x28 in. National Child Welfare Association, 70 5th Avenue, New York City.

Foot Posture Posters. For use in educational campaigns, in schools and clubs. Better adapted to adults than children. 15c per set of 7; $10 per 100 sets. Woman's Press, 600 Lexington Avenue, New York City.

Foot Tracing Charts. (1) Do your feet have good arches. (2) Is your big toe straight? For use with foot posture posters. 10c per set of 2; $10 per 100 sets. Ditto publisher.

Health and Character. Especially designed for work among negroes. 10 panels, $8; 17x28 inches. National Child Welfare Association, 70 Fifth Avenue, New York City.

Health Charts. Thomas D. Wood, M. D. 48 charts, valuable in presenting health problems to parents and teachers. $7, plus postage. National Council of Education, 525 W. 125th St., New York City.

Health Strength Joy (Poster). The child health seal in black and white. Free. Bureau of Education, Washington, D. C.

Healthy Babies and Children. First series. Full set of 25 panels, $25; 13 panels on Healthy Babies, $13; 12 panels on Healthy Children, $12. National Child Welfare Association, 70 Fifth Avenue, New York City.

Second series; full set of 25, $20; 13 panels on Healthy Babies, $11; 12 panels on Healthy Children, $10. Ditto publisher.

History and Physical Examination Form. William R. P. Emerson, M. D. 10c each. Nutrition Clinics for Delicate Children, 44 Dwight St., Boston, Mass.

Home Rules of the Health Game. A card of health rules. 2c each. Dietetic Bureau 376 Boylston St., Boston.

Hygiene for School Children (Posters). These posters cover the most important rules of hygiene in a way which children can understand. 12 panels, $10; 17x28 in. National Child Welfare Association, 70 5th Avenue, New York City.

Milk Posters—Children Need Milk; Eat More Milk; Milk, the Perfect Food. Charts useful in teaching the use of milk. 5c each. New England Dairy and Food Council, 51 Cornhill, Boston, Mass.

Food Comparisons; Spend Your Money Wisely; The Dairy Cow. In black and white; size 22x28 inches. 8c each; 5c each per 100. New England Dairy and Food Council, 51 Cornhill, Boston, Mass.; also National Dairy Council, 910 S. Michigan Avenue, Chicago.

Magic of Milk. 20x27 inches; tinned top and bottom. 16c each; 13c each per 100. Ditto publisher.

Milk Posters. Comparison of the value of coffee and milk. Obtainable in Italian, Hebrew and Polish translations. Free in the State. Massachusetts State Department of Agriculture, Dairy Division, 136 State House, Boston, Mass.

Modern Health Crusade Creed. Marie Halsey Stryker. A card. $1.25 per 100. Philadelphia Health Council and Tuberculosis Committee, 10 S. 18th St., Philadelphia.

Modern Health Crusade (Posters). The panels take up the eleven Chores of the Modern Health Crusade. 12 panels, $10. National Child Welfare Association, 70 5th Avenue, New York City.

Nutrition Class Record. 2c each. Dietetic Bureau, Boston, Mass.

Oral Hygiene Chart Miniature. Many small pictures teaching oral hygiene. Free. The Kolynos Co., New Haven, Conn.

Plack. Silhouette blue and cream plack of Child Health Seal; use as class honor award in health competition. $3 each, plus postage. Child Health Organization, 370 7th Avenue, New York City.

Posters (of the Chicago Turberculosis Institute.) William Donahey, de signer. A set of 10 health posters of a boy and his dog. $1 per set. Chicago Tuberculosis Institute, Chicago.

Posters (Photographs). Lucy M. Queal. 5x4 inch photographs of most attractive posters on foods and health. $1 per set of 12. Lucy M. Queal, Massachusetts Agricultural College, Amherst, Mass.

Posture-Poise (Poster). A tennis girl in colors. Free. Woman's Press, 600 Lexington Avenue, New York City.

The A1 American Boy. Present health ideals and outline health habits for American boys. 10 panels, $8; 17x28 inches. National Child Welfare Association, 70 5th Avenue, New York City.

The A1 American Girl. To stimulate practical ideals of womanhood in American girls. 10 panels, $8; 17x28 inches. Ditto publisher.

Weight and Height Records

Adult Weight Card. Metropolitan Life Insurance figures. Average weight of men and women in pounds with clothes. $2.25 per 100. The Riverdale Press, Brookline, Mass.

Average Height, Weight and Age for Men and Women (Card). 2c each; $1.50 per 100. Iowa Tuberculosis Association, 518 Century Building, Des Moines.

Class Room Weight Record. Space for names and monthly weights of pupils. 5c per single copy; 2c each additional copy. Superintendent of Documents, Government Printing Office, Washington, D. C.

Right Height and Weight for Boys. giving average weight for height and Thomas D. Wood, M. D. Wall chart age Free. Bureau of Education, Washington, D. C.

Right Height and Weight for Girls. Thomas D. Wood, M. D. Wall chart giving average weight for height and age. Free. Ditto publisher.

Tables of Weights in Relation to Height and Age. William R. P. Emerson, M. D. 10c each. Nutrition Clinics for Delicate Children, 44 Dwight St., Boston, Mass.

Weight Card (for Girls and Boys). Thomas D. Wood, M. D. Vest pocket size, showing proper relation between weight and height from 5 to 18. $1.10 per 100; $8.25 per 1000. Child Health Organization, 370 7th Avenue, New York City.

Weight Chart for Children in the Home. William R. P. Emerson, M. D. 16x21 inches. 10c each. Child Health Organization, 370 7th Avenue, New York City; also Woman's Home Companion, 4th Avenue, New York City.

Weight Chart for Use in Nutrition Classes. William R. P. Emerson, M. D. 10c each; $9 per 100. Ditto publisher.

What Is Health? (Poster). Silhouette of children in black and white. Free. Bureau of Education, Washington, D. C.

MOTHER AND CHILD

A Magazine Concerned With Their Health

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The Art of Health

Rev. Charles Kingsley

Three persons out of four are utterly unaware of the general causes of their own ill-health, and of the ill-health of their children. They talk of their "afflictions", and if they be pious people, they talk of the "will of God" and of the "visitation of God". I do not like to trench upon those matters, but when I read in my Book and in your Book that "it is not the will of our Father in Heaven that one of these little ones should perish", it has come to my mind sometimes with very great strength that that may have a physical application as well as a spiritual one, and that the Father in Heaven who does not wish the child's soul to die may possibly have created that child's body for the purpose of its not dying except in good old age. When one sees an unhealthy family, then in three cases out of four, if one takes time, trouble and care enough, one can, with the help of the doctor who has been attending them, run the evil home to a very different cause than the will of God; and that is to a stupid neglect, a stupid ignorance, or, what is just as bad, a stupid indulgence.

From an address in 1857 before the Ladies' National Association for the Diffusion of Sanitary Science.

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"Our Boys" Enter Luxembourg

Luxembourg Days

Wm. F. O'Donnell,. M. D.

JANUARY 1919 instead of bringing us our expected and longed for orders to proceed to the coast for embarkation, presented us with instructions for a move to Walferdange, in the Grand Duchy of Luxembourg, and assigning us to the Army of Occupation. Our first feeling of disappointment and chagrin was shortly overcome by our curiosity regarding this little country and with the well-known American attitude of "Lets go," we impatiently awaited the move.

January 24th, we moved from Commercy, France, up through the Verdun sector, and on Saturday afternoon arrived at the city of Luxembourg, the capital of the Duchy.

Having to wait over in the yards for a half hour or more several of us decided to take a peep at the city. The streets about the station

were crowded with men, women and children apparently with their best clothes on and enjoying themselves as if on a holiday. Imagine my surprise when, two days later, my landlord Herr Wolff-Dumont told me that I had been the unconscious spectator at a revolution, not a real revolution but a Luxembourg one. The Grand Duchess was deposed, taken in a closed conveyance by some of the State officials to one of her estates over the German border, and her eldest sister given the throne. While this was going on the people declared and celebrated a holiday. Holidays in Luxembourg we afterwards found were religiously observed on the slightest pretext; one of the boys jokingly observing that the Luxembourgers would celebrate a Mexican National holiday if they knew of it.

Later in the afternoon we arrived at Walferdange. Walferdange is the railroad station for one of the Grand Duchess' palaces and four small surrounding villages. The Duchess, through kindness, had tendered the use of the schloss with its spacious grounds and conservatories for hospital purposes to the American Army.

THE SMALL BOY COMMITTEE

Hardly had our train stopped before the customary small boy reception committee put in its appearance. Throughout our stay in France we had been functionating in the Zone of Advance and we were immediately impressed by the change in the appearance of the children. Instead of the ragged, thin, sophisticated, street gamin whose knowledge of English was limited to "Gimme cent, cigarette, chewing gum, etc.," and other expressions not usually part of a child's vocabulary, we saw a group of well dressed, rugged, clear-eyed, frank boys, whose natural curiosity was kept admirably in check by good training, and who when spoken to replied in excellent German, and with a degree of reticence and bashfulness so attractive in children. No need of guards and frequent "allez" to prevent the disappearance of small articles as "souvenir Americain." It was particularly noted that no girls were in the group, a fact easily explained as the young girls on their return from school either had household duties to perform or played together immediately in front of their homes.

IMPRESSIONS OF FAMILY LIFE

The floor space of the schloss was so limited that the officers and some of the men were billeted in private homes. It was my good fortune to be with Herr Wolff-Dumont, a prosperous shop-keeper and wine merchant. The family consisted of the Herr, his good Frau, and three daughters, Maria aged sixteen, (be sure to pronounce it correctly as Marie and Mary were the names of servants), Nathalie aged twelve, and Leopoldine aged eight. A short time found me adopted as their big brother,

and as such my stay was everything to be desired.

The home life was wonderfully intimate. School lessons were prepared after dinner in the sitting room, mother helping the younger children, kindly criticizing and giving friendly encouragement as necessary, until the next day's lessons were properly prepared. The father read the daily paper until all were through. If I were asked what qualities of the children impressed me most I should list them as obedience, industry and application. Throughout my stay the unqualified obedience to parents continually impressed me. This was probably helped by the parents, who, when a disagreeable request was to be made, softened the request by a few words of explanation until one was glad to do it. This close association between parent and child particularly manifested itself after study hours when the conversation became general, as much attention being paid to the youngest as to the oldest. If interest lagged, father always had a joke or two, or started playing games until bedtime. During these talks, the events of the day occurring to each were gone

The Country-Side With Its Trellises For The Grapes

over, and kind words were spoken of every one.

GAMES AND TASKS

Maria was a very capable housekeeper and practically managed the home upon her return from school, the mother being more or less busy through the day and evening in the store. The two younger children after going whatever errands were necessary played in the immediate vicinity of the house. Their games consisted of "mothers" with dolls, school, and a ball game, catching a rubber ball in a wicker funnel. While at school and at play the children wore colored aprons which were removed before coming to the table at mealtime.

Language, mathematics and penmanship were apparently the most important branches in school, while little attention was paid to history and geography. The eldest girl in addition to German, French and Luxembourg (spoken language only, probably a hybrid of German and French), had a fair knowledge of English acquired at the pension in Luxembourg City, 8 kilometers distant. The children as a rule wrote a very good hand and were adept at calculating, which was necessary as marks both German and Luxembourg, francs both French and Belgian were accepted in payments for purchases. After a month or so the conversation before bedtime was practically a lesson in conversational English, and it was rather difficult to spend an evening conversing in either French or German, as they had nothing to gain by my acquaintance with these languages, excepting possibly in a negative way.

CHILD HEALTH AND DISEASE

Physically the children were distinctly German in type, good hair, clear eyes, wide nose, large mouth, and rather plethoric. Their well nourished contented appearance was a distinct contrast to that of their parents, who before the Swiss and French borders were opened actually went hungry so that the children would have sufficient. Meats and sugar were particularly difficult to get. The prevalent disorders as far as I could ascertain were gastro-intestinal during infancy, and in older children affections of the tonsils frequently followed by peritonsillar abscesses and middle ear disease. Deafness, in one or both ears was not uncommon in this locality. In the group about Walferdange, were about 350 people, but I remember seeing only two babies under three years of age. Infants were breast fed, and maternity cases attended by midwives or friends. During a slight gastro-enteric attack I saw the nursing infant of the school teacher, who upon completion of supervision presented me with a letter of recommendation to show other patients what a good doctor I was. This would have been quite a valuable asset to a Walferdange physician as the school

teacher was second only to the Mayor and Padre in importance in the community. This being the custom in addition to the paying of a fee, it would seem to be of assistance in choosing a doctor. If you had a headache and went to a doctor unknown to you, you need only ask him for a list of his recommendations for headache cures.

A SOCIABLE CITY DOCTOR

Towards the end of our stay in Walferdange, the youngest child, Leopoldine, developed a mild attack of typhoid fever. Insisting on having a Luxembourg physician called in, that the Health Department regulations be complied with, I had the pleasure of observing his methods. After introductions, we went to the sick room. He asked the mother one or two questions, and without an examination of any kind pronounced it acute enteric fever, stating that there were no Health Department regulations to be observed. In all we were not in the room three minutes. Going to the living room the better part of the next hour was spent in imbibing the best wine from the cellar, telling jokes and making merry generally. Regretfully I have to admit I lacked one of the prime requisites of a successful physician and had to cease being sociable long before the time limit. His fee was 75 francs. Only once or twice a year was it thought necessary for some one in Walferdange to call in a physician, the nearest physician living in the city of Luxembourg.

A peculiar trait noted not only in the children but also in the elders was an apparent lack of national pride. Every country had something better than they, and it seemed as if belittleing ones home attractions was accepted as a broad viewpoint.

It was uncommon during the summer to see a child barefooted, and one of the attractions of new shoes was their musical sound. Having occasion to have a pair of shoes half soled, and finding the tune unattractive to my ear, I returned them to the cobbler to silence the squeaks. He indignatnly told me he knew his business, and whoever heard of a pair of new shoes or newly soled shoes that did not make a noise. My last knowledge of these shoes was hearing them go up a church aisle on the feet of a proud farmer. For a time it was puzzling to know why a number of young men neither sat or knelt in church. Rather than bag the knees of their trousers, they preferred to stand, which gave evidence that they wore a new or nearly new suit.

SOCIAL CUSTOMS AND AMUSEMENTS

It was a rule that no respectable woman or girl was seen on the road after dusk unaccompanied by either husband or father. It was permissible for a Maria to go with a John to a cafe to dance during the day, but if they wished to go in the evening, father, mother, all the brothers and sisters accompanied

Maria, who met John at the hall and danced, while the rest of the family ate, drank, were merry or asleep. The journey home was made with the family likewise. In the cafe, the orchestra often consisted of one man with a pedal, pressure on which rolled a snare drum; attached to his knee was the stick to the bass drum; smoking a cigarette while he played an accordian. It was customary for two young men to dance and leave the young lady to sit the dance out. It was not proper for two young ladies to dance together.

Looking backward over my stay of five months in this picturesque country, I am impressed with the kindness and jollity of the head of the family, the industry and meekness of the mother whose entire interest lay in her home and children, the obedience to and love of parents shown by the children, the intelligent understanding which parents exhibited in the handling of their children making obedience a pleasure rather than a duty, a combination which made the home the center of attraction not only for the elders, but for the youth.

The Place of Nutrition in Bringing the Undernourished Child Up to Normal*

E. V. McCollum and Nina Simmonds

School of Hygiene and Public Health of the Johns Hopkins University

IN the fields of medicine, economics and government, the child has received attention much later than the adult. Within recent years a great deal of attention has been given by various agencies to child welfare, and there is considerable difference of opinion as to the relative importance of the several lines of procedure whose aims are to improve the physical condition of children. Prominent among these are the school clinic; the dental clinic; the open air class with rest periods; the school lunch; provision for regular weighing and measuring, especially with the dispensing of lunches; nutrition classes; instruction regarding correct posture, and so forth.

These agencies all have laudable aims and ambitions, and we may look forward to each of them holding its place for years to come. In many instances two or more of these are working together, and with good results, and this is as it should be, for the problem of improving our children's prospects of growing up stronger, and capable of living happier and more efficient lives, is a many-sided one.

*Paper read by Miss Simmonds in the National Conference of Social Work, Milwaukee, June, 1921.

It behooves us to restrain our enthusiasm for our own special lines of interest, and to grant that no one has a monopoly on this great work.

SURGERY VERSUS NUTRITION CURE

We have repeatedly come into contact with medical men who take the view that the one really worth while agency for the improvement of the health of school children is the clinic. They point to the remarkable improvement of children who are in bad physical condition after having their tonsils or adenoids removed. Malnutrition, they say, is generally the secondary result of handicap of some kind which the clinic can remove. They believe that if sufficient food is available, the choice of articles which enter into the diet is a matter of relatively slight importance. We believe that this view can survive only in the minds of those whose knowledge of modern research in nutrition is archaic.

On the other hand among our visitors are not a few who feel that almost the antithesis of this view is the really sound one. They have been occupied in teaching boys and girls of school age what to eat and how much to eat, and, without any surgical treatment, numerous children under their observations have resumed growth, and have developed a healthy appearance, even though harboring enlarged tonsils, or carrying other handicaps to health. These workers remark upon the extent to which a properly nourished child can tolerate poisoning through infected tonsils or abscessed teeth and still maintain its normal rate of growth. There is much evidence that this is true, but this fact does not serve as an argument against the clinic.

There are many cases of children showing all signs of malnutrition who have had at least a diet sufficiently good to have enabled others in the family to grow in an apparently normal manner. Such cases can only be accounted for on the basis that there is some other factor which is primarily responsible for their poor condition. In most cases this group have been injured by one or more of the contagious diseases of childhood, and have not been able to overcome their handicap. There seems much reason to believe that throat and nose infections are in most instances the sequel to such injury in infancy or early childhood. Where a pathological condition has definitely developed the rational thing to do is to introduce surgical treatment where it has a prospect of success. Only those who take a narrow view of the subject would be inclined to deduce from such evidence, that attention to diet is a matter of relatively little importance in such cases.

Everyone now accepts the view that there are fundamental similarities in the physiological processes of man and the lower animals. Al-

most all that we know about human physiology is based upon deductions from experimental results obtained with animals. In a comparable degree we have derived our knowledge of the principles of nutrition. There are several diseases of man, which are directly caused by specific faults in the diet. These can be produced experimentally in animals, and their natures and causes are well understood. Animals require the same food-stuffs for their maintenance and growth as does the human species. We have in recent years gained a most remarkable amount of knowledge of the extent and manner in which a properly selected diet can promote health. Few are familiar with the results of these studies, for the reason that they are new, and that they have appeared in numerous scientific papers which it was not easy to study with sufficient care to master their meaning. It is just as absurd for anyone, whatever his technical attainments in another field of knowledge, to form an independent judgment as to the bearing of food selection on health, as it is for one who has no detailed knowledge in any field to assume to have judgment comparable to an expert in that field.

In our laboratory during the last few years we have studied the problem of nutrition with an animal colony, in which we have duplicated human experience with respect to diet, insofar as the human diets in various parts of the world represent distinct and widely different systems. Our studies have included much work with the strictly carniverous diet; the vegetarian diet, the diet largely derived from cereals, tubers and meats; the diets in which dairy products find an important place, and so forth. We now understand the extent to which we are to expect success in the nutrition of animals from any practical combinations of natural foods.

In addition, we have, however, gained information which is much more to the point of our present discussion than the technical data regarding the peculiar shortcomings of this or that natural foodstuff, as shown by our biological method for food analysis, although the latter is actually the basis of much important knowledge as to how to secure definite effects by combining foods whose properties are known. I refer to the effect of diets of definite composition, derived from different sources, on the life history of the individual. We have learned that it is necessary to consider the life history of a man or animal in order to gain a proper perspective in regard to the role of diet in the preservation of health and longevity. It is not sufficient to look at a child or an animal at any given time and to say it looks essentially normal, and on this evidence to dismiss further thought as to its welfare as this can be influenced by diet.

In the first place our standards

of what constitutes normality in children and adults are lamentably at fault. We take as the "normal", approximately the average physical development with which we are familiar, rather than the optimal development as represented by the best developed members of the community. These last should be taken as our standard toward which to work in the case of all. The attainment of such success can be expected only when the diet is approximately the optimum with respect to all its parts.

When we regard the human problem in the light of standards gained through animal experiments, we cannot help concluding that changes which have taken place in the diet of the people of Europe and America during the last century, have tended to seriously undermine vitality, to lead to easily observable physical inferiority, to shorten the period of productive life, and to hasten the onset of the signs of old age. In human experience other factors such as hygiene, sanitation, disease, injurious occupations, overfatigue and worry, enter as complicating factors. In our animals we have studied the effects of diets of different character, entirely apart from any other variable factors influencing the life history of the individual. There can be no doubt that this is the very cornerstone of the entire structure which we are trying to erect for the protection of mankind. Its importance must not be overrated but anyone who studies the results of our experiments during the last ten years cannot help being convinced that there is nothing more fundamental in the production of bodily vigor and the maintenance of high resistance and longevity, than a properly planned diet.

It is not the startling failure of those who suffer from the deficiency diseases which should hold our attention, but rather we must appreciate the much more common, and more insiduous, because unsuspected, effects of diets of the meat, bread and potato type which are so common in this country and Europe in modern times. In our latest research on the cause of rickets, a disease which has existed for thousands of years, we have definitely settled the problem which has been discussed for centuries, viz., the nature of its cause. We have shown that the diet is the one factor which is primarily responsible, although other evil conditions may predispose to it. This disease, characterized by faulty bone growth is a national health problem and is essentially a dietary one.

Space will not permit more than a few passing remarks on the subject of our discussion here, but a certain feature of the problem looms up larger and larger as our experience become more extensive. That is, that irrespective of the agency which operates to improve the physical condition of our children, the work which is being done with the child of school age is es-

sentially a salvaging operation. We may remove a focus of infection, free it from difficult breathing, repair its teeth, or teach it personal hygiene, but we are at best but repairing for temporary service and temporary relief, a damaged human being. By the time a child has reached school age it is already past the time for anything very fundamental in establishing a vigorous constitution. We can add many years to its life in many cases, and increase comfort and happiness, and make it a more useful citizen, and this reward is sufficient to warrant all the effort which we can expend upon it. The extent to which we shall meet with success will be determined—will depend—in great measure, on inherited vitality.

The opportune time to attain the maximum benefits of proper nutrition is in prenatal life and early infancy, and more effort should be directed toward education of mothers concerning the benefits to be derived by their children, as the results of right living on their part. Before the teeth are erupted their enamel is already formed. If it fails to form a satisfactory union in the places where it meets as it extends away from the primary centers of enamel formation on the cusps, no amount of care and scrubbing will serve to preserve the tooth. The time when the teeth are forming is a critical one in the life of the child, and the secret of preventive dentistry lies here, in proper diet of the mother during this period. This goes far back of the school clinic and of the age at which other agencies are attempting to reach the child and teach him health habits. Once the teeth are formed they cannot be improved in any marked degree, but we are possession of information which would gradually bring us back to the condition of satisfactory dentition enjoyed by our ancestors.

In conclusion therefore, we would call attention again to the types of diets which succeed in the nutrition of man and of animals. They are the strictly carniverous type, in which practically all parts of the animal are eaten; the type so common in parts of the Orient, that is, that in which the leafy vegetables such as spinach, cabbage, lettuce, turnip tops, beet tops, and other leaves, find a prominent place in the diet; and lastly the diet such as we use in America, containing liberal amounts of milk and other dairy products. The trouble is we do not consume enough of the *protective foods,* milk and the leafy vegetables. These are so constituted as to correct the faults in a cereal, legume seed, tuber and meat diet such as is so common in our country today. The sooner we carry this information to every child in the land, and send him home with this message to his mother the sooner will we have started on the right road toward better health and better physical development.

Training Attendants to Care for Well Children

Katharine Shephard, R. N.

[The need of training methods for young women who are to care for well children is one of the urgent problems of child hygiene endeavor. How Boston is solving the problem in a practical way is told in Miss Shephard's article.—Editor.]

FOR nearly three years, The Household Nursing Association in Boston has been training attendants to care for the sick.

A registry for attendants was maintained in the school building, 222 Newbury Street, on which the names of the pupils were placed as soon as they completed their course in affiliated hospitals. They were sent out on private duty, under the supervision of graduate nurses, for six months, after which time they received their diplomas, and were free to remain on the registry, or to work independently.

Calls were constantly coming in for attendants to care for well children. As we could not fill all our sick calls, we were obliged to make a rule that attendants could be sent to care for well children, only if the parents were either ill or absent, so that it was absolutely necessary to have someone in the house capable of taking responsibility. From this, originated the idea of giving a short course of training for young women who wished to prepare themselves to take intelligent care of children. After completing the course, these women could be placed on our registry, and we could be reasonably sure of finding them employment at good wages, and would have some knowledge of their character and ability to give to their employer.

In order that the students might have some first hand knowledge of ordinary nursing routine, arrangements were made with the Convalescent Home of the Children's Hospital to give practical training following our course and lasting 42 weeks, a diploma to be given at the end of the year. The Convalescent Home has always had nursery maids, but has never considered itself a training school.

THE COURSE IN DETAIL

The course given at the Household Nursing Association was arranged to cover twenty lessons, two evenings a week, for ten consecutive weeks. The tuition fee was $12. The lessons were given in the evenings to enable working girls to come in the hope that they might be interested to continue their training in the Convalescent Home. The outline of our course is as follows: Ethics and Personal Hygiene; Baby Hygiene, including a study of how a normal baby develops and the care of a well baby; Child Hygiene, showing how a normal child develops and care of a well child; Phys-

ical training of a child, including studies of how to form good habits, the care of the teeth, eyes, hair, skin, bowels, and sleep habits; Mental Training of Child in regard to obedience, truthfulness, correction of bad habits, play and table manners; Nursery Hygiene including a study of ventilation, temperature, cleanliness, care of bed, napkins, flannels, and so forth; Common Diseases of Childhood with special attention to Observation of symptoms, Reasons and Precautions; Tuberculosis in Children and the Milk Question; Simple Treatment in Nursery Emergencies and Talks to Girls.

The first ten lessons were didactic teaching. In the second part of the course, dealing with foods and cooking, practical demonstrations were given to each student. Cooking Lessons included Milk Modification with a study of sterilizing or pasteurizing; recipes for whey, junket, barley, and oatmeal gruel; the preparation of cereals, toast, white sauce, orange juice, baked apples, apple sauce, stewed fruits; preparation of vegetables including potatoes, spinach, and creamed carrots; cream soups; eggs, coddled, poached, scrambled, shirred, egg-nog, preparation of meats for broths, beef juice, beef steak, and chops; Milk desserts such as custard and rice pudding; preparation of sandwiches and lunch boxes, and suggested menus for the children of pre-school age.

The Superintendent of the Household Nursing Association and her assistant worked out the course together, using material from the course of instruction at the Boston Children's hospital, of which they are both graduates. Much valuable help was given by Dr. Richard M. Smith's "The Baby's First Two Years", and the government bulletins written by Mrs. Max West. Dr. Smith's book was used by the girls as a text book. Some suggestions were obtained from the course for Nursery Maids, given at the D. A. Blodgett Home for Children, in Grand Rapids, Michigan.

PERSONAL HYGIENE POPULAR

The lessons on Personal Hygiene were suggested by a doctor's wife, who had entered her nursery maid for the course. She asked us to lay special stress on the necessity of frequent bathing, and care of such personal details as having the boot heels built up, and the frequent changing of stockings and underclothing. This lesson was given with some misgivings, fearing that it might be displeasing to the girls, but, it was received with eager attention and copious notes were taken.

In fact, all through the course the interest of the girls has been most encouraging to the teachers. They ask intelligent questions, and there is usually a most animated discussion after each lesson.

In the lesson on Common Diseases of Childhood, the teacher was careful to explain only the early

symptoms of the diseases, and the duty of the nurse maid to tell the parents instantly of any little change in the child's physical condition.

A life size baby doll was used for a model, not only for demonstrations of dressing and bathing, but in later lessons, to illustrate correct posture and proper handling of the child. In the lesson on Child Hygiene, much emphasis was laid on nutritution and rest periods during the day.

The last lesson was a talk given to the girls by a physician employed by the State Department of Health.

In the cooking lessons we felt very uncertain whether it would be possible to interest the girls in cooking such simple food. It seemed absolutely necessary to have a cooking teacher so full of enthusiasm that she could hold the interest of the pupils. The young woman who taught the class realized this difficulty, and managed it very well, so that the girls stirred gruels and baked apples apparently as enthusiastically as if they were preparing French pastry and baked alaska.

Learning to Do by Doing

We were at comparatively small expense in giving the course, as the teaching was done by members of the staff. We used the pupils' class room for the lessons in Theory, which were given by the Superin-

tendent's Assistant, and the well equipped diet kitchen for the cooking lessons, which were taught by a Simmons College Graduate.

There were fifteen pupils in the first class, of which ten were nursemaids sent by their employers. One woman who took the course, had done office work until her marriage. She said she was her own nursery maid, and wanted to be a good one. This suggests the possibility of giving young mothers classes in the care of children.

One interesting pupil was a Siamese princess, who is studying "Child Welfare". She took the course, which was planned entirely for girls with very little education, so that on returning to Siam she might know how to teach her people in the simplest way.

We have been very much encouraged by what we have heard from women who sent their nursery maids. They tell us that after the first few lessons, the entire attitude of the maids toward their work changed. They seemed to realize how responsible a thing it is to have the care of a little child. One girl told her employer that taking care of children had seemed to be just an easy way of getting a living, but now she understood the real importance of her work. This alone seems to justify our experiment.

The Mental Health of the Child

By C. Edgerton Carter, M. D.

IN connection with my pediatric work at the Orthopedic Hospital School of Los Angeles the interdependence of the mental and physical has loomed so large it has seemed worth while to emphasize this relation as a factor in the mental health of the child. Of course the general consideration of "mens sana in sano corpore" needs no stressing. In a vague way we are all conscious of that relation. It is to impress the direct causative action abnormal physical conditions may have specifically upon the child's mental hygiene that the subject is discussed from this physical angle.

The great difference between the treatment of crippled chronics who exhibit biased mentality and the child of normal mentality with "inclinations" toward physical defect, is that of conservation. In the chronic cripples, marvellous reconstructive work is done, but at best it is reparative. In the mental normal, the future possibilities are so much greater that eventually we shall have "Preventive and Corrective Clinics" for the pre-school child as we now have Medical and

Surgical Clinics for the afflicted.

One such clinic under the management of the Federation of the Parent Teacher's Association in Los Angeles has made a modest beginning. Its purpose has been to give the supposedly well child of pre-school age from two to six years of age an opportunity to become a superior child. Instead of attempting to restore to possibly normal the ill or defective child, we start with the apparently normal, and endeavor to give him endurance and robustness which are requisite for superior attainment. Incidentally, we find more than three-quarters of the children examined reveal varying abnormalities of more or less consequence. Naturally these defects are corrected. So the clinic proves corrective as well as educative.

BETTERING THE AVERAGE

But the crux of the problem lies in the attempt that is made to better the average—to surpass the "fairly well" standard of the present, and to inspire parents and children toward being (and doing) better! The returns noted in this clinic already have vindicated its need. And the conviction that correction of chronic physical defects liberates new mental forces has caused the Orthopedic Hospital-School in Los Angeles to materialize for the explicit purpose of training these resultant mental abilities coincidentally with treatment, often tedious, which the child's crippled condition demands.

HEALTH STATUS CHART

A Health-Status Chart* is in use in the Clinic as a method of presenting the physical findings to the parents. Children who, upon superficial examination impress one as being sound physically, are found to reveal, not uncommonly, a health status from 60 to 75 per cent normal when charted upon the basis of values! These charted values are arbitrary, and may be modified to meet individual conditions after the method of Doctor Gietz in Santa Barbara, and as is done with the private patients of the writer. The one requisite is that health essentials be emphasized.

So largely is preventive work among children a question of parental education, and so impossible of enforcement are personal health measures, that mental hygiene, to be applied, must have a practical and elemental basis which appeals to the comprehension of the parents. For this reason, by approaching the subject through the medium of the physical defects and disorders, concerning which the parent has an intimate knowledge, one finds a welcome avenue to a fertile field. It matters little whether the parent completely comprehends the reflex processes by which results are obtained upon mind and character through these

*This chart is reproduced in the California State Health Bulletin, June, 1919.

physical determinants. The vital fact is that this intimate association exists and that the intangible can be reached through the tangible. Thus the parent comes to realize that improvement may be accomplished in temperament and ability, specifically through these physical health measures. That is: Tonsils have long been enucleated for the relief of septic absorption, and because of their deleterious effect upon the blood stream and general metabolism—little argument is needed on that score—but that slightly diseased tonsils should be removed to prevent cardiac involvement is a step farther, and such procedures are usually accomplished because of the parents' confidence in the physician, rather than because they are convinced of any real danger. The third step in the argument for the removal of pathology, or for the correction of defects, that is,—that the child's mental development will show definite response to such treatment, requires for a convincing presentation, not only the enthusiasm of the believer, but knowledge of actual experience.

A practical method of physical examination whereby comparisons of conditions may be appreciated at a glance, is a necessary corrollary, for parents readily bridge the gap between the physical status and its possible effects upon mind and disposition, provided they can be convinced that the child's condition is sub-normal. Here graphic charts serve an essential purpose in this educational step since the physician is thus enabled to translate his findings to the visible scale which represents the condition with reasonable accuracy.

INHERITED AND ACQUIRED TRAITS

Perhaps upon no other claim has there been laid greater burden of proof than that of heredity! Parents too early are satisfied to let Jimmie be thin because his father is; to permit Mary to refuse vegetables because mother does; to tolerate an irritable, nervous child because he is "high strung" and so forth, while the possible inheritance of value from the parent, the character impress made by daily example, are given little thought! It is so much easier to fall back upon the hackneyed excuse "he inherits that from his father". (Poor Father.)

Undoubtedly we reflect our own uncertain attitude when we fail to urge upon the child the acquirement of a taste for all wholesome food, and healthful games. Homely, simple food for body and mind must form the foundation of any stability in health or character. Yet so much in our likes and dislikes is explained upon the basis of "heredity" that unconsciously we allow our children to form pernicious tastes in the choice of food and in the formation of habits. Instead of the child "inheriting" a dislike, he acquires a fixed antipathy through the daily imitation of a parent lacking control and

wholly unaware of thus influencing the tastes and, through them, the growth of the child.

Often food impressions are left to the haphazard choice of a nursemaid abetted by the whims of a difficult-to-please child. Food dislikes, idiosyncrasies in eating, may be the direct and only cause of nutritional disturbances resulting in rickets, flat foot, bony deformities and other developmental defects. Here the psychology of the mother (assuming that she has the intimate charge of the child) affects the physiology and growth of the child; this in turn gives an undeniable twist to the outlook on life of the child, and may figure in the distorted philosophy which the resulting adult so easily acquires.

One of the old established and influential religious orders is credited with the dogma that given a religious training until seven years old, the child will never depart therefrom. In no other instance, apparently, do we find a well recognized and accepted working hypothesis that takes into account this pre-school period as a possi- the determinor of the child's future.

It is a period, nevertheless, in which imitation of conduct, temperament, and habits hold supreme sway. Reason and Decision not yet formed—Imitation and Imagination are dominant. The influence that health has upon mentality, and habit upon health is not appreciated. If it were, the pre-school child in the family of ideals would not be permitted to "drift" into a haphazard physical condition as he is today. He would receive at least as much routine attention as does the family automobile, toward keeping his combustion perfect and his "machinery" in order.

POOR BODILY MECHANICS

In other ways than by diet, however, can the child's mental growth be encouraged. Right physical hygiene fosters healthy mental hygiene. The influence of carriage upon conduct, of posture upon principle, is too well known to need more than passing mention. "Poor bodily mechanics", quoted by Fritz Talbot and Lloyd T. Brown of Boston, are responsible in great measure for at least three abnormal conditions. These in turn act as nerve irritants and affect the mental horizon.

Perhaps the commonest and least considered physical cause for defect in character development is found in the ubiquitous "flat foot" or broken down arches of the foot. Indeed, it is doubtful if in our psycho-analyses we ever give "flat foot" a thought, as being a possible factor in establishing the child's mental hygiene. Analyze for a moment the component elements of character, and we find "application" or stick-to-it-iveness" a sine-qua-non in all well balanced minds. This is a quality implying the ability for persistent

effort. Let the child find that standing tires him, that long tramps over the hills leave him exhausted and without appetite, that tennis makes his back ache, that skating causes his feet to pain him, and we soon have that child losing interest in these physical efforts, yet by such physical efforts demanding skill, strength, and endurance, are bodies made symmetrical and minds trained to coordinate. In a word, this is true—the boy who doesn't enjoy out-of door contests, loses the greatest possible stimulus to clean character building. He is handicapped by this loss of mental training in perception, comprehension, courage, and coordination which contests give. Weak arches are directly responsible for many mollycoddles in boys and girls. The condition of constitutional asthenia to which Doctor Thomas Lewis has applied the term "effort syndrome," and which Kerley pertinately says permits of "poor student material," 50 per cent of which should be scrapped and put to productive occupation, is not always found in inherited weaklings. Physical handicaps may be their mental retardants and, in many cases, these are conditions which are preventable only during the early formative years.

ANATOMICAL FAULTS

Again, while Nature starts us forth physically equipped with heads asymmetrical, legs unequal, ears imperfect and eyes astigmatic —not all such stigmata have an appreciable effect upon character. One common anatomical fault leaves its mental mark because of the intimate association that necessarily lies between breathing and effort. Without argument, we all agree that courage and control are desirable qualities to cultivate in the budding mind, yet the boy with ineffectively approximating jaws, with teeth failing to function because of malocclusion, is barred by reason of this defect from a fair chance in the game of life. His utmost physical efforts are made unnecessarily difficult. Observe him whose teeth do not effectively approximate and you will find that he does not excel in feats which demand the clenched jaw of determination "to do or die." However, malocclusion receives attention only because of its influence upon mastication or for cosmetic effect. It deserves a more serious consideration, for an "Andy Gump" type of facial contour is not to be chosen as winner in any endurance contest, physical or mental, while the man with the vise-like jaws of Roosevelt, carries no handicap during the formative years of childhood as he clicks them together in friendly rivalry or determined effort to overcome. Children with the undeveloped lower jaw have been needlessly handicapped by adenoids or dental malocclusion, and their mental training is made easier if these physical deformities be corrected.

THE PREVENTION OF DISEASE

Opportunity for giving a national uplift to the health of the future is apparently at hand. Statistics of the draft examinations in the United States revealing the now well-known rejection for physical defect of every third young man under thirty-one years, have proven most unexpected food for thought. Permit the briefest possible reference. Our athletes have beaten the world, mortality and morbidity rates have shown amazing decrease in diphtheria and typhoid, our resources have seemed exhaustless — until we have taken it for granted that to be "a young American" was equivalent to winning "the three score and ten" lease on life. Cold statistics convince us there is on the contrary, a lien on the lease, which will either seriously embarrass the life activities, or stop them altogether, in a million men supposedly of the Nation's strength. How does this directly relate to the child's mental hygiene? Physical handicaps are to be prevented only by educational influences wisely and constructively utilized among our children. The five groups of defects or diseases, constituting over three-fourths of the million rejected, fall within the limits of diseases preventable or possibly correctable if seen early. These same conditions are incurable if advanced. It is to the effect upon the reconstructed lives which children so afflicted must form, to the influence these abnormalities have upon mentality, that present emphasis is laid.

1. Heart disease heads the list, is not curable and so ranks first as a physical determinant on future efficiency. To treat this as a physical problem merely, without a consideration of the mental warp and fear-psychoses the confirmed cardiac exhibits, is to beg the question. The prevention of heart disease is emphatically a problem of childhood, but the burden of its weight is distributed throughout the years that remain, be they few or many.

2. Tuberculosis with its roster claiming distinguished and brilliant minds the world over, shows its prevalence in the war data, when every tenth man or over 100,000 of the flower of our youth was afflicted with the disease in active process. The point in preventive work is that infection begins in childhood, has already decimated the health ranks of our young men, and even though the mental impress may be exhilarating and stimulating, instead of depressing and fear-inspiring, as in chronic cardiacs, both diseases are factors in the mental outlook, and the pre-school age should be the time for their consideration and prevention.

3. Nutritional disorders per se with their sequelae of bony distortions and developmental defects, claimed another third of our rejected young men. A third of a million youths, whose fundamental nutrition was defective, proves we have much to teach (perhaps to

learn) about elemental body requirements and food balance. These deficiencies in nutrition are from ignorance, not poverty.

Children with chronic indigestion or constipation, or with faulty bodily hygiene, are not the ones who radiate happiness. It is furthermore impossible for a child to develop a happy outlook upon life, who doesn't habitually feel well, and the habit of being well carries with it the possible habit effects upon mental and moral qualities.

It is not at all uncommon for the pediatrist to encounter children of six or seven years who complain of "the hardness of life"—whose brows are already wrinkled in habitual brooding, and whose mental attitude is habitually apprehenhensive. These children are not defective, nor are they normal children suffering from the occasional upset which is part of childhood, but are already "chronics", and as surely growing up into social agitators and fault finders, disgruntled with themselves and their associates, as are the border line cases and degenerates, productive of morons and criminals. The latter classes are congenital, and a problem set apart, but the embryo pessimist is not one decreed by Fate, nor does he become that from choice, but rather because of a wrong habit-hygiene, moulding his psychology, in his habitual attitude toward the world. Truly, in childhood, bread and brains are partners, and the child with unbalanced diet, cannot be an apt pupil in mental hygiene.

If in this present discussion there is suggested a means whereby the pre-school child may be "dry-docked" every three or six months, from two to seven years, and freed from the barnacles that retard his mental progress, ultimate good will come in far greater measure than physical findings indicate.

The Schools' Responsibility

Harriet L. Leete, R. N.

FIELD DIRECTOR, AMERICAN CHILD HYGIENE ASSOCIATION

THE statement that every child has a right to health, happiness, education, and equal privileges is incontrovertible in a democratic country whose citizens are broad-minded, sympathetic, and loyal to high ideals.

In spite of these accepted affirmations, the returns from the Army Draft Board visualized for us with disillusioning certainty the fact that, as a country, we were woefully lacking both in health and education, and that our defects, and our illiteracy were traceable to neglect in childhood.

Many demonstrations and statistical reports have forced us to realize that good health is one of the foundation stones upon which to build the educational structure. It

is therefore characteristic of our keen, alert educators, that they should ask what their responsibility is in the development of a health program.

While fundamental truths have been accepted, the school health experts tell us that the premises have not been taken accurately, and that procedures have not been outlined with sufficient definiteness. However, we appreciate that great progress has been made in child health, environment, and in training, through Medican Inspection of Schools; Recognition and Treatment of Malnutrition among School Children; and Physical Education Instruction.

RESULTS OF MEDICAL INSPECTION

Medical inspection has been carried on with such great success in many schools that I shall quote some statistics with which you are undoubtedly only too familiar. Still, this unpleasant record must be spoken of, for until we actually corfect the defects found, we must face them as evidence of laxity in our health control. On examination of 20 million school children, the findings show: One per cent mentally defective; five per cent tuberculous (now or in the past); five per cent have defective hearing; twenty-five per cent have defective sight; fifteen to twenty-five per cent have diseased tonsils or adenoids; ten to twenty per cent have deformed feet, spine or joints; fifty to seventy-five per cent have defective teeth; fifteen to twenty-five per cent suffer from malnutrition. Such reports indicate that the first step towards rendering assistance has been taken —that of discovering the causes of poor health in our children.

Under five years of age 300,000 children die annually, and of these deaths, a large percentage is due to communicable diseases, and more than this, many children go through life with deafness, low resistance, and other health limitations because of the lack of early recognition of communicable diseases.

When Boards of Education and tax payers realize that it is cheaper to have nurses in the schools to assist the teachers in the prompt detection and isolation of contagion, than it is to have epidemics running rampant, then one big problem will be solved, and there will be less sorrow and suffering caused by inadvertence and neglect.

There will be fewer cardiac cases, fewer enlarged tonsils and adenoids resulting from scarlet fever; there will be fewer cases of bronchopneumonia, following measles; the child's resistance need not be lowered by a long course of whooping cough; and perhaps one great asset will be the prevention of damaged nerve cells, a condition following in the wake of communicable diseases, and frequently not recognized.

Then how can we best meet the present emergency—for it is an emergency if youth is crippled or in any way handicapped for lack of health development.

I wish to preface any suggestions which I may make with the statement that premises taken by me must be understood to be only personal ones, for the formulation of definite procedures must be made by workers actually engaged in practical demonstration of the problem, and it is clearly understood that the American Child Hygiene Association does not specialize in school health programs, but the Association recognizes the great need of such programs, and the inestimable value of the contributions made by the various organizations in the school health field.

The part which the teachers throughout the country have played in the health development procedure in the schools, has been wonderful. That they could so graciously and enthusiastically accept a new subject and add it to their already crowded program, confirms the opinion of Dr. Helen MacMurchy, of Canada, when she said: "All reformers, sooner or later, come knocking at the school room door. Our only hope of reconstruction is through education."

We concede that happiness and health development of every living child is under the control and influence of the home.

We know that all organizations interested in the health of the child from the pre-natal period through adolescence, have been confronted with the veritable truth, that further development through extension of Educational work has been limited because of our present lack of national and state financial cooperation.

We, therefore, ask just what is the relationship of the home, the school and the state?

HOME SCHOOL AND STATE

I call the present situation an emergency, for our time is altogether too limited in which we are to give the school children their greatest opportunities, hence, I am sure every one will approve of the wisdom of a plan which at once mobilizes all of the forces of a community into one council, which will define the duties and privileges of each health group, in order that every available person may render the greatest assistance without any over lapping of services. The school health group will include, whenever possible, men who understand the value of properly constructed school buildings, with satisfactory lighting; men who understand the necessity of good sanitation; men who know that too much labor with a lack of recreation is even economically a poor beginning for life's duties; men who will be willing to plan for open air schools, when such schools are necessary.

Each community can best develop its own organization, but it would seem logical that the medical profession should accept the responsibility for physical examinations and the curing of defects; that volunteers render every assistance towards making it possible for children to be put in touch

with the physicians; that nutritional workers, under whatever name, whether local or field workers from the State Extension Departments, make available for use all information relative to diets; that public health nurses are most needed in home control and in school inspections; while teachers can adapt the teaching of health to their other schedules and so interest the children by a most effective ppresentation of the subject.

OPPORTUNITIES FOR SERVICE

The regular Volunteer Service and the Volunteer Motor Corps Service have just as great opportunities now as was given to them during the War; services which may not be quite so spectacular, quite so intense, but even more far reaching in their influence. The problem of transportation is one of the weakest links in the chain of better health for children, and volunteers might well make the forging of the link possible.

Parent-Teacher and Congress of Mothers' Associations have become so actively interested in child welfare, their assistance will be invaluable. When formed in a council and facing the problems of how to cover the subject most efficiently, the National League of Women Voters can find no more profitable way of working than by convincing our representatives in the Government that a budget which appropriates 92.8 per cent for military purposes, and 7.2 per cent for the Civil Expenses of the government, including health, has a conception of values which is altogether out of proportion to real values, if we are to be the leading nation twenty years from now.

In other words, Kipling's verses about the army might well be applied to our school army program:

"It ain't the guns nor armament,
Nor the funds that they can pay,
But the close cooperation
That makes them win the day.

It ain't the individual,
Nor the army as a whole,
But the everlasting team work
Of every blooming soul."

THE A. B. C.'S OF HEALTH

It is because the organizations interested in the pre-school age child, have not been able to accept their responsibilities as fully as they would wish, that such almost unsurmountable difficulties have been thrust upon the schools. May the time soon come when every health officer in the schools will receive from responsible organizations, a record of the child on entrance to school, which will indicate his previous home environment, kind of pre-natal care given, nutritional schedules properly supervised, health habits formed and defects corrected. Then educators will be able to teach both in theory and by demonstration even in the younger grades, the principles and procedures necessary for good health in our children; the children will grow up with as distinct a knowledge of the A. B. C.'s of health as they have of educa-

tion. The responsibility for this broad training must be assured by universities and normal schools where the teaching of health will be given as regularly as are now other recognized subjects; for at present, health problems are little included in a training for teaching, and teaching methods have been equally neglected in most of the training schools for nurses. It would seem that the task was assigned before opportunities and privileges were given to our health instructors in our schools, but that in the future an awakened public conscience will make available opportunities and privileges (which will include adequate salaries for teachers); and that financial support will be given to this most important subject in our school curriculum. A knowledge of the principles of child welfare in the home, in the school, in the church and in the state, practically safeguards the nation; "For, after all, the sole hope of any nation is with the children of the country."

Dr. Farrand has said, "The whole fabric of our American democracy rests in the school. Nothing must be done by any organization that does not fit in with and is not welcomed by educational authorities."

Briefly, then, there are opportunities and obligations which rest:

First—Upon teachers of vitalizing health teaching through the use of health plays and other methods which will stimulate the imagination and interest of the child by adapting to and incorporating in their regular curriculum the rules of health.

Second—Upon administrators of making it possible for teachers to receive the necessary inspiration and instruction in order that they may, with force and interest, teach this most important of all subjects.

Third—Upon taxpayers to realize that money spent for health is the most economic, most wise, biggest dividend paying investment that they can make. For it is well known that "healthy boys and girls are more efficient, more teachable, more law-abiding than are handicapped children."

This should make us realize that no price is too great to pay for healthy children.

We have not yet recovered from the awful cataclysm of war; psychiatrists tell us that the peak of nerve strain and after results following shell shock will not be reached for five years. This prophecy has so startled us that organized efforts have been made to meet the urgent need. The childrens' need is equally great, but will the citizens of America within five years, fully realize their responsibility to their children, and actually make it possible for them to get a square deal?

Most of the problem is an economic one and we must squarely face it. If we do not face it we will be a losing nation, in the world race. On the care and the opportunities we give our children of today (and I plead especially for the children in the most isolated communities) rests the whole future of our country. It is not the responsibility of any organization alone, but of every individual in the community, and through our schools we must meet this tremendous responsibility fearlessly.

Central American Congresses

TWO congresses relating to children are to be held in September in Central America as part of the Independence celebration. The First Central American Child Welfare Conference will be held in San Jose, Costa Rica, beginning Sept. 15, 1921. The Central American Teachers' Congress will take place in the City of Guatemala from September 11 to 20. The programs of both these conferences show the earnest consideration that is being given by Central Americans to the care and education of their future citizens. In the building of a strong nation much may be done by good legislation; but more may be accomplished by wisely directing the physical, mental, and moral development of the rising generation. That Central Americans are following modern tendencies and advanced methods along these lines may be seen from the following programs:

The program of the First Central American Child's Welfare Congress is as follows:

CAMPAIGN AGAINST CHILDREN'S DISEASES

1. Sanitary inspection of milk.
2. Free medical consultation for children under 2 years.
3. Foundation of an open-air school for children.
4. Opening of a ward in the Sanatorio Curit for tubercular children.
5. Vacation colonies for school children.
6. Special children's hospital.
7. Collection and study of the statistics of causes of infant mortality.
8. Foundation of society for the protection of children.

HOUSE SANITATION

9. Houses for workmen; contest for models of workmen's houses in city and country.
10. Prizes for poor children who with little or no expenditure beautify their homes and render them more sanitary.
11. Prizes for the best large gardens and home gardens made by children.
12. Improvement of conditions in the schools.
13. A "clean-up" campaign and the inculcation of the habit of cleanliness.

DIETETICS

14. Frequent publication, for free national distribution, of pamphlets containing lists of inexpensive foods, their values, and their nutritive content, with rules for food preparation and advice on hygiene.

GENERAL CHILD CULTURE

15. Teaching of child culture in the schools.
16. Opening of a children's reading room in the National Library.
17. Elimination of street begging by children.
18. Choice of games and exercises suitable for developing the physique of children.
19. Establishment of a juvenile court to handle all children's cases.
20. Foundation of a house of correction for wayward children.
21. Addition of manual training work shops to every school, in which those not preparing to study a profession may learn a trade.
22. Development of persistence and the desire to succeed by effort.
23. Propaganda in the schools against the manufacture and use of alcohol—*From the August, 1921, Bulletin of the Pan-American Union.*

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A Spreading Faith

The difficulties that beset child hygiene programs in certain Southern States are often dwelt upon, not only by field workers who have been missionaries in certain sections below Mason and Dixon's line, but also by health officials in the southern cities who are familiar with rural conditions in their respective vicinities. It is interesting therefore to find evidence in the current news that the seeds of health education are not falling on sterile ground when they happen to drop beyond a certain historical line. In the *Public Health Nurse* for June, 1921, we find two interesting bits of news:

"An open-air clinic for midwives was conducted last year by a public health nurse in a grove near Marrs Bluff, a small village of South Carolina. Within a radius of eight miles, twelve old colored mammies were found who were practicing midwives, and who came to the meeting place the first time because summoned by the authority of a 'government nuss'. Later they came because they enjoyed it. After the summer's course, several of them were able to qualify as registered midwives."

The only probable comment might be that the public health nurse in question must have been an unusually capable instructor. Again we read:

"So many babies in Tampa died last fall, or were found to be blind, that the work of the midwives was called to the attention of the city physician. An ordinance was passed requiring all midwives to be registered, and making it a requirement for registration that they should take a course in hygiene of midwifery and pass an examination."

Aside from the right or wrong of the question as to whether this procedure will do any good, it is an evidence that Tampa is taking its infant mortality problem to heart, and endeavoring to help herself.

So called "plantation practice" in times past was ignored in many southern states. Louisiana specifically exempted "plantation practice" from the operation of her midwifery law. But the old days are passing—fortunately. That a serious effort is being made in many states previously conspicuous for lethargy in matters of public health

is manifest not only in the news contained in health magazines, but also in the columns of the lay press. From Tennessee, comes a piece of news, which is very promising; we quote the *Memphis Press of June, 17th* 1921.

"An effort to discover the cause of the high infant mortality rate in Memphis is being made by the city health authorities, who are making a study of a thousand consecutive deaths of children in order to find out the immediate cause, the location, family condition, environment, and pathological history of each case. A special department of child hygiene will be created in the health department, with an expert in charge."

With South Carolina and Florida and Tennessee facing their health problems, and sister states having done or preparing to do work of equal importance, it is quite evident that the doctrine of public health and child welfare does not draw either historical or geographical lines in its diffusion throughout the length and breadth of the land.

The Increasing Maternity Risk

The Metropolitan Life Insurance Company does a great deal of medico-social work, although it is not a social welfare organization in the ordinary meaning of that term. Insurance companies have a practical interest in the longevity of people of all classes; they make a business of studing morbidity and mortality statistics very closely. Their observations and conclusions on these subjects have a definite money value and are not undertaken from purely philanthropic motives. All the more reason, then, why we should regard statements made by these companies as fairly authoritative in the field of vital statistics.

When over 23,000 mothers in the United States died during the year 1918 as a result of childbirth, it was assumed that the terrible epidemic of influenza had increased the death toll of the mothers to an unusual height, and that we were really not falling behind in our efforts to protect maternity. But now come the statistics of the Metropolitan Life Insurance Company for the year 1920, showing that maternal mortality is increasing. In 1920, 13.6 per cent more mothers died in giving birth to children than in 1911, nine years previous. In 1920, an increase was shown over 1919, the figures in 1919 showing 20 deaths per 100,000, while 22.5 mothers per hundred thousand died in 1920. This statistical retrograde is so ominous and so disconcerting that the Metropolitan Life Insurance Company has decided to inaugurate a nation-wide investigation of maternity conditions. The statistics will be tabulated with the hope that the information so obtained may be useful in the institution of measures for saving the lives of mothers. Everyone concerned with national welfare will be benefited by the results of such a study.

The Day's Work

NEW HAVEN'S TEMPORARY HOME FOR BABIES

Mrs. James K. Whittemore has written the following account of how New Haven provides emergency care for babies:

"During the war, there was started in New Haven, a temporary home for soldiers' babies, where they could be cared for during the mother's illness or disability.

"This work, which was taken over by the Civic Protective Association after the armistice, has been continued and enlarged, as it has been proved to be just as much needed in peace as in war times. In this city it is the only home where babies under four may be sent for temporary care. The babies cared for may be divided into two classes: First, those whose homes are for a time disorganized because of illness, loss of financial support, or other misfortune. These babies are cared for until the crisis passes, or adjustments are made.

"The second group are those whose homes, through death or disaster are broken up. These children are kept until a permanent home can be found for them. Into this group, also, fall some of the babies of unmarried mothers, though many of these find temporary shelter with their mothers in the Girls' Home of the Civic Protective Association.

"The real need of such an institution may perhaps be best proved by its increasing growth, and by the fact that fifteen local charitable organizations, and two state organizations, besides many private individuals, have in the last year referred cases to the Home.

"The Home is an interesting and pleasant place to visit, a large, old-fashioned house, in the quieter part of the city. It stands in the midst of its own grounds, facing south, surrounded by fresh air and sunshine. Within, it has been completely remodeled, and equipped with all the modern sanitary arrangements of a small hospital. The verandas on the first and second floor face south and have been enlarged and screened so that it is possible to move all the cribs out of doors in the warm weather.

"This establishment houses on an average eighteen babies—about half of them under a year of age and the others between one and four years. They stay in the home from two weeks to several months. When they come to the Home they are almost all undernourished and underdeveloped.

"Each child must be examined in the New Haven Dispensary before admission, and no sick child is admitted. If any child develops a fever it is immediately placed in the isolation room, and then sent to the hospital.

"Five child specialists of the city give their services to the institution, each for a period of two months. They visit the Home weekly and are always on call.

"A moderate charge is made when parents or relatives can meet it, but about a quarter are enrolled as 'free cases'.

"A few statistics may help to indicate the varied character of our cases. The total number cared for during the year was ninety-eight; in 32 cases cases the mothers were in the hospital, 3 mothers were in a tuberculosis sanatarium, 5 mothers were insane; 3 babies were deserted by one parent, 15 were illegitimate children. The other 40 were cared for while various home adjustments were being made. Five homeless mothers, not yet strong enough to work, were cared for with their babies. One mother has now become a valuable member of the house staff. Forty-four children were returned to parents, 23 were placed in boarding homes, 15 were transferred to other institutions, and 16 were in the home when this report was made.

"I need hardly enlarge upon the boon to sick mothers offered by this safe shelter for their babies, the relief of mind brought to the social worker, who may take time to find the right home in which to place the child, the help and courage given to the homeless mother, who, weak and without friends, leaves the hospital, her infant in her arms, her future all uncertain."

"OUT OF THE MOUTHS OF BABES"

"Little Health Folks" is an attractive pamphlet on health subjects prepared entirely from the composition work of the primary children of the Rockford, Illinois, public schools, and the pupils of the fresh air school. It contains riddles, stories, health rules, and so forth, and concludes with a pageant. The book is a result of an effort to make health teaching a vital part of each day's work in school.

BOYS AND GIRLS COMING TO CANADA

The emigration of children from Great Britain to Canada has long been encouraged by both countries, and since the movement began over 73,000 boys and girls, the former predominating, have been brought to Canada, the great majority of whom have served apprenticeship with farmers and have followed agriculture as a vocation, according to the Canadian Department of Immigration and Colonization.

The report shows that the success of the system has been due to the satisfactory early training of the children and careful selection for migration, and to wise choice of homes and good supervision. Because of the existing social and economic conditions in England the subject of emigration is receiving increasing attention in that country. (*Report of the Chief Inspector of British Immigrant Children and Receiving Homes, "Juvenile Immigration* 1919-1920.")

SAFEGUARDING THE HEALTH OF NEW YORK CITY'S CHILDREN

AN account of "School Medical Inspection in New York City," by Dr. S. Josephine Baker, D. P. H., appeared in the *Monthly Bulletin of the Department of Health,* for May, 1921.

Dr. Baker says that the department of health has for some years used a uniform scale called the Dunfermline scale as a basis for grading the nutrition of school children. A striking increase in the amount of malnutrition began to manifest itself in 1914, which reached its apex in 1917, and since then has shown a slight but regular decline. During the past two years the department has received special cooperation from the department of education in combating conditions of undernourishment among school children. From its years of experience in dealing with the problem, the department feels that the condition, at least as it exists among New York children, is not necessarily caused by lack of food. The predominant causes have been the wrong type of feeding, irregular feeding, and lack of personal hygiene, the latter including insanitary surroundings, inadequate sleep, too much nervous excitement, and so forth. The solution of the problem of the undernousirhed child can not be brought about by the provision of any facilities, however adequate, for dealing with children who are already undernourished; the program must be based upon preventive lines, similar to those which have been so effective in baby saving work.

GETTING THE YOUNGEST PHYSICALLY FIT TO ENTER SCHOOL.

Examination of the pre-school children who are to be registered in school next September was begun on May 31 in several selected schools in Manhattan, through the combined efforts of the Bureau of Child Hygiene, Department of Education, Red Cross and the Civic Club. The work will continue till the end of the present school year, and it is expected that about a thousand children will be examined. Arrangements will be made to have as many of the physical defects corrected as possible before the children enter school. At the beginning of school and thereafter a study will be made of the effect of the removal of defects upon the mental status of the children, the later examinations being conducted under the supervision of the Department of Education. (*Weekly Bulletin, Department of Health, N. Y. City,* June 11, 1921.)

TEAM WORK FOR HEALTH.

A community health center is to be opened in East Harlem through the cooperation of the 13 welfare and public health agencies operating in that district. The organizations will come together, for the most part, under one roof, and will coordinate their work by means of frequent conferences. The project will be under the direction of a

health center council, in which each of the agencies concerned will have a representative. The Red Cross will also be represented as well as leading citizens of East Harlem. This district, which includes Little Italy, is one of the most congested in the city. (*Better Times,* June, 1921.)

FOOD LESSONS FOR FOREIGNERS.

A restaurant for undernourished children was conducted for six months by the Bowling Green Neighborhood Association, which works in a district that is the home of many newly arrived immigrants. The plan of the restaurant was to instruct the parents in the preparation of a well balanced diet within their means, and to demonstrate its benefit to the health and mentality of the children. Cooking classes for mothers were held and 41 undernourished children, from 5 to 13 years of age, were given three meals a day for periods varying from one to six months. A canvass made since the closing of the restaurant showed that 62 of the 148 homes visited were following the diet regulations taught. Thirty-six of the children were weighed again, and it was found that twenty-eight of them had continued to gain. (*Better Times,* June 1921.)

SENIORS RETURN BORROWED BABY

"Dicky Domecon", the baby loaned to the Home Economics Department of the College of Agriculture at Cornell for practice work in training the girls in child care, has grown to be a healthy, normal child and is soon to be adopted into a permanent home. For a year he has been cared for entirely by the senior students in home economics, who took him when he was three weeks old.

COUNTY CARE OF CHILDREN

The bill creating a county board of child welfare to look after the needs of destitute, neglected and handicapped children in Sussex County, New Jersey has received the signature of the Governor. The new law centralizes the responsibility for child care within the county, by transferring to the new board the powers and duties of the present board of child welfare which administers the mothers' pension system, and of the poor law officials as they relate to children. (*State Charities Aid Association News,* May-June, 1921.)

COUNTY NUTRITIONAL CLASSES

Education work in nutrition classes is being developed in Schuylkill County, Pennsylvania, under the direction of the Home Economist. Miss Elinor R. Mills, of the Anti-Tuberculosis Society. School children are weighed and measured, and those found to be under weight given tags showing the amount of their underweight. On the reverse side of these tags are simple suggestions for bringing the weight up to normal. Special classes are formed for the children who are more than ten per cent underweight. Twelve such class-

es have already been formed in various schools of the county, most of them being held in the school buildings, during school hours. The 285 boys and girls in these classes are being taught how to gain in weight, special emphasis being placed on well-balanced diets. The preparation of oatmeal, other cereals, vegetables, and other good foods for children is demonstrated each week, and a bulletin containing the information given in the class talk and demonstration is given to each child to take home.

The gain which each child makes is recorded on an individual chart. Colored circles are also marked on these charts if they take a daily nap, go to bed early, drink no coffee, eat oatmeal, and drink three glasses of milk each day during the previous week. If a child fails to gain normally a doctor's examination is secured.

The nutrition worker does some home visiting and is also securing the cooperation of community nurses and interested mothers in helping carry the work into the homes. The gains in weight, and the children's improved physical condition are already proving the practical value of this type of county nutrition class work.

DENTAL HYGIENISTS

A course for training women dental hygienists will be offered at the University of Pennsylvania Dental School, in September, at the request of the State department of health. The purpose of the course is to train women to serve as teachers in schools, hospitals and private dental offices, and to make them capable of thoroughly cleansing the mouth and teeth, and discovering the need of expert dental attention. —(*Jour. Am. Med. Assn.,* June 4, 1921).

PHYSICAL EDUCATION IN COLORADO SCHOOLS

The Supreme Court of Colorado has decided that the school board of Denver has the right to provide for the physical examination and physical education of pupils in the public schools, and to employ the necessary personnel. The court also holds that the employees of the school engaged in such work are teachers, within the provisions of the laws of Colorado. (*Trained Nurse and Hospital Review, June,* 1921).

PHILIPPINE ISLANDS MOTOR HEALTH SERVICE

A public health ambulance is to be fitted out by the department of public health for service in different parts of the islands. It will carry clinical and surgical material for the treatment of accidents and diseases, lantern slides, films and public health models. — (*Jour. Am. Med. Assn.,* June 11, 1921.)

SAVING EYESIGHT AND EYE STRAIN

The Annual Report of the National Committee for the Prevention of Blindness, for the year 1920, shows that conservation of vision

classes in the public schools now number 62, of which 12 were established in 1920. They have been opened in 8 States. Detroit has the first high school class of this kind, and its students hold their own with other classes, and even win honors. To meet the rapidly increasing demand for trained teachers and supervisors for this work, the department of education at Harvard University offers a special course of instruction, which opened with 77 students in attendance.

New York City and Minneapolis have eye clinics in the public schools.

The census of schools for the blind, made by the committee, shows that ophthalmia neonatorum holds its place as the chief cause of blindness among children, the percentage of blindness from this cause being 22.5. Massachusetts and Ohio lead in work for the prevention of blindness from this cause.

MEN'S CLUBS GIVE HEALTH TALKS

A course of 12 lectures on hygiene and sanitation has been planned by the Nashville Commercial Club, with the assistance of the Rotary and other clubs of the city. The lectures, which will occur once a month during the coming year, will be given by prominent Nashville physicians. The subject of the first lecture, in June, was Nashville Babies; the July lecture, by the city health officer, was on Nashville School Children.

BABY-CLOTHES WANTED

The American Friends' Service Committee, with headquarters in Philadelphia, has sent out an appeal for at least a million dollars worth of clothing before autumn, for use in Poland, Vienna, Germany or Russia, according to the wishes of the givers. Among other things, it asks for unlimited quantities of baby clothing. The need is said to be as great now as at any time since 1915. (*New Republic,* June 22, 1921.)

MISS LEETE IN THE WEST

Miss Harriet Leete, R. N., the Field Director of the American Child Hygiene Association, gave one of the evening addresses at the Joint Session of the Oregon Conference of Social Workers' with the Northwestern Sectional Conference of the Graduate Nurses Association in Portland, June, 1921.

Miss Elnora Thomson, R. N., summarized the questions discussed as to "What the Social Worker May Expect from the Health Worker," and as to "What the Health Worker May Expect from the Social Worker".

DELAWARE COMMISSION'S DIRECTOR

Dr. William J. French of Washington, D. C. has been chosen to direct the Delaware Child Welfare Commission. This Commission was created by act of the Legislature in 1921 to take over and develop the work of the State Reconstruction Commission. An annual appropriation of $60,000 was provided for in the bill.

The Foreign Field

A HOME FOR BOYS WITH DAMAGED HEARTS

J. Anderson Smith, M. D.,
Medical Officer of the Edgar Lee Home

FROM the medical point of view the establishment of an institution such as the Edgar Lee Home for the reception of cases of heart disease in young boys could hardly have come about at a more interesting period than the present, for during the last few years, thanks mainly to the work of Sir James Mackenzie, Lewis, and others, our attitude towards the phenomena of heart disease has undergone a change that is well nigh revolutionary.

It is not so long ago that to discover a murmur was to label the unfortunate subject a case of heart disease, to treat him as an invalid, a piece of brittle china likely to break on the least shock, to exclude him from all those games and exercises which were the joy of his life, to fence all the pleasantest paths with glaring notice boards, shouting "you mustn't go here", "You mustn't do this"—to warn his relatives that his life would probably be a short one, or if by chance a longer one it would be a creaking all the way—in short, to treat him as one of those predestined ones so hauntingly described by Maeterlinck.

If the doctor happened to be one of those comforting, easy-going practitioners, when pressed as to the meaning of it all, he might have gone no further than to say that the boy had a "weak heart," which to the lay mind is a comfortable a word as "scarlatina" in the place of "scarlet fever." If, on the other hand, he had been of the precise, unbending, gloomy order, he would have talked of "valvular disease of the heart," with all the dread associations of that term (sudden death, hopeless incapacity, and chronic invalidism).

Now the pendulum is all the other way, and all is changed and changing: today we attach small importance to the murmur, great importance to the muscular efficiency of the heart, and the greatest importance of all to what the heart can do. It is a kind of pragmatic doctrine *in excelsis*. If you can swim and jump and dance and run without disastrous, or even far short of that, without undue effects, then no matter what the stethoscope may say, you need no longer consider yourself an invalid.

The very passport to freedom is to show that after all these things your pulse is still fairly normal, your heart fairly regular, your breath not unduly short, your general condition no worse than it was before. In short, the problem is *solvitur ambulando*.

Which of these views is correct? As far as my personal practice is concerned, I have acted during the past year on the assumption that the modern view is the correct one, and so far the results at the Edgar Lee Home confirm this view, for as we shall see presently, the boys there do dance, do run, do play games, do drill, and under limits are allowed to behave as if their hearts were as sound as their spirits were willing and eager. The only rule there laid down, *ceteris paribus,* is that if a boy shows no undue breathlessness, no rapidity of pulse after each display of energy, he may continue. On admission every boy is carefully examined, and if there is reason to suppose he could not do these things, he is watched and put on probation until a definite opinion can be ventured.

Let me quote two cases in illustration:

A boy, age 12, looking the picture of health, but presenting to the stethoscope an orchestra of murmurs such as I have never heard before or since (so unusual that even an experienced physician like Dr. Price, of the Heart Hospital, who kindly saw the boy with me, said he had not heard the like) such as to make me afraid to let him join the happy throng: but a little later when I ventured to let him loose, he was described by the matron as the most adventurous, the most daring of all these young playmates, and he has now left the home quite as well as when he came in.

A boy who came in with injunctions from his mother that he was on no account to be allowed out of bed, and the very idea of his playing any game would have made her take him out of the home instanter: a few weeks later I saw that boy playing a bow-and-arrow game as a Cockney Red Indian.

As against this happy side of the picture I contrast the few cases of mitral stenosis we have had: they do not respond in this pleasing fashion. The few cases of advanced mitral regurgitation, with enlarged liver and dropsy, that we have had have been transferred to other hospitals. Here the bulk of the cases are in a more or less compensated state when they reach us, and all those have either held their own or improved. We have had very little rheumatism, and with the exception of four cases of diphtheria (all of whom recovered) no adventitious illness. The boys are happy and contented, well looked after, and provided with the games suitable to their capacities—croquet, mild cricket, punch ball. They are drilled and attend school on the premises, being taught by a capable mistress who understands their disabilities, and does not overeducate them, and yet tries to prevent their minds becoming fallow.

A question I have often asked myself, and that I am sure will be asked by my readers, is, how far

is a special home required for these boys? Is there any justification for a special home where cardiac cases are alone admitted? Would they not do equally well at an ordinary convalescent home? Well—quite apart from our results as seen in the general improvement of the boys, and the absence of any deaths—I should say the chief gain lies in the association of boys all more or less crippled from the start, that is, all starting from the same level, so that in any kind of competitive exercise, the boy with cardiac disability has to compete with a boy suffering from the same kind of disability handicapped in the same way, and not with a boy whose heart is sound. It is a similar problem to that of the neurasthenic, the soldier suffering from shell-shock. Some said it is better he should mix with sound men, and so strive to emulate them, but I think experience has proved that the effort was more than they could bear, and it has been found better to keep the shell-shocked to themselves, where a fellow-feeling made them wondrous kind, and where the encouragement derived from seeing the improvement that occurred in patients like themselves acted as a stimulus, and outweighed the disadvantages of seeing the misery of their fellow sufferers. Something similar occurs at the Edgar Lee Home, although of course, in a less degree, for the average boy is happily free from self-consciousness, and blissfully unaware, unless he has spent his life as a hospital bird hopping about from one hospital perch to another, of his internal economy, and is much more likely to over-exert than under-exert himself.

The kind of case that I should hope to get the best results from is that of a boy who is convalescent from his first attack of rheumatic fever, and left with a damaged heart. Such boy cannot be kept indefinitely in a hospital: if sent home he has to contend against the rough energy of healthy brothers and sisters, and is encouraged to do more than he ought, or on the other hand treated as an invalid and allowed to do less than he might.

The Edgar Lee Home is not to be looked upon as a hospital where modern cardiology can be studied. That sort of work is better done by experts who are specially trained and have the necessary apparatus at hand and the skill to use it. Their hands are sufficiently full. But when all this is done, there is room for a place where the boy can get something like the freedom and comfort of a home and pull himself together, where he need not fear the electro-cardiograph, the polygraph, and all the paraphernalia of a modern heart hospital. Splendidly useful as it all is, there comes a time when the patient says "Let me alone, leave me in peace." I am sure the aim of the

founders of the Home was not primarily the scientific treatment of heart disease but rather the after-care treatment. Leave to hospitals the accurate scientific diagnosis, the initiation of treatment, the care and control of severe acute cases, and there is still a vast residuum which needs constant watching and prolonged supervision, if the good originally done is to be maintained.—*Charity Organization Review,* January, 1921.

Scotland

TODDLERS' PLAYGROUNDS

Lady Helen Leslie MacKenzie makes a strong plea for the organization of toddlers' playgrounds. Lady MacKenzie says:

"The Edinburgh Voluntary Health Visitors became greatly impressed with the poor condition of many of their 'ex-babies'. Many a fine infant of twelve months, healthy and actively growing when they left off visiting it, seemed to dwindle into a very puny, listless, neglected little mortal at eighteen months or two years, without any joy in life, and many of them without the will or capacity to play.

So a suitable open space with covered shelter and sand-pit was secured in a congested area. Toys were collected, mostly from friends. With one paid worker and two or three volunteer assistants, they cared for thirty or forty children. These toddlers were chosen from homes where there were a young baby, and several school children. With the school children at school and the toddler in his superintended playground, the mother is enabled to attend both to her baby, and to the preparation of the midday meal. In time for the midday meal the toddler is taken home, and has the rest of the day to look forward to his next visit to the playground.

Admission to the playground is conditional: First, there must be a baby at home needing nursing; second, the mother must undertake to prepare the school children properly for school, and to prepare the toddler for transference to the playground; third, she must maintain a reasonable standard as to tidiness in the home. Thus the homes are stimulated to maintain a better standard, the mothers' energies are economized, the baby receives more attention, the toddler has improved not merely in habits, but materially in health. One test of the health improvement has been noted by the medical man in attendance. At first, noses were constantly "running", and cleaning noses seemed the day's work. But after a few months of the daily open-air life, the discharges dried up, and nose conditions became normal.

The children were taught to play, and at first very few knew how. They sat cringing in corners, and were very difficult to amuse or rouse. But before long, child nature reasserted itself, and

today the "toddlers' playground" has a noisy, boisterous, free and safe crowd of really healthy, happy children, preparing to be drafted on to the free kindergartens where mind and manner will be further prepared for the elementary school.

Every main block of houses should have its toddler's playground. If the playground is to have its full effect, it must be near the house, easy of access, and superintended with skill. It then becomes a day-camp for physical education: its primary purpose is to establish the children in vigorous health.

If it is asked why the toddler cannot play with other children, the answer is clear. The child of one to three needs protection in his play. To leave him to children older than himself is to expose him to risks that cannot be controlled. Yet, on occasion, nothing is more beautiful than the tender care the children of five or six spend on their brothers or sisters of one, or two, or three. To leave the toddler to play by himself is to impair his development. To secure to him the highest physiological value of play, he must be placed in the charge of a skilled and sympathetic person. It is then that the toddlers' playground becomes a center at once of health and education. It takes him away for the moment from the rigid mechanism of pavements, dark stone stairs, and packed immobilizing rooms. For all the rich hour or two, he misses none of the responses in the subtle ritual of Nature."—Taken from *Carnegie United Trust Fund,* Vol. III.

France

The appropriations for maternity and infant welfare in the national budget for 1921 were as follows: Subsidies to departments and communes taking measures to bring about an increase in the birth rate, 3,000,000 francs, the same amount as in 1920; assistance to women in confinement and to nursing mothers, 25,200,000 francs (11,000,000 francs more than last year); other appropriations connected with maternity and infant welfare, 7,322,000 francs. The total of the appropriations exceeds the total of last year for the same purposes by 15,050,000 francs.—(*Journal Officiel,* May 1, 1921.)

Endowment of Motherhood—A measure has recently been proposed to the Chamber of Deputies providing that every mother of French nationality, belonging to the working classes, shall be entitled to receive 360 francs per annum, for each child under 16 years of age who is not earning wages. This measure would prevent children from working too early and lessen the burdens of parentage. The fact that the measure has been widely approved in the Lower House is a proof of the acute stage reached by the population problem.—(*Lancet,* May 7, 1921.)

Legal consultations at a maternity hosptial — At the instigation of the director of the Maternity Hospital in Paris, a well-known lawyer has undertaken to hold legal consultations one morning a week in the hospital, and to give free advice on such subjects as registration, legitimacy, marriage formalities, and so forth. This is an interesting experiment, which promises to be of real value.—(*Maternity and Child Welfare,* May, 1921.)

BABY SAVING SHOW

A National child welfare and maternity exhibit was held in Paris, June 15 to July 25, 1921. Two congresses convened during the exposition,—the congress of the 51 French leagues on repopulation and higher birth rate, and a congress of departmental commissions on infant welfare. An extensive baby saving show, free distribution of toys, and of baby garments, and the formal presentation of the Famille francaise were among the closing features of the exhibition. —(*A. M. A. Journal,* May 21, 1921.)

RED CROSS PLAYGROUNDS

A demonstration playground was set up in Paris a year ago by the Junior American Red Cross. France has half a dozen playgrounds of the American type. The Red Cross has now been asked to launch the movement in Belgium and Italy. It will equip and supervise one in Charleroi, a town in the part of Belgium which suffered most during the war, where supervisors will be trained for playgrounds soon to be started in other Belgian cities. Within a short time the playgrounds will be taken over by the local authorities. The first playground in Italy will be located in Florence, where it will form part of a large community center project for the care of war orphans. As soon as it is in successful operation it will be taken over by the center committee. —(*Playground,* June, 1921.)

Austria

"Infant Welfare Work — Miss Edith M. Pye, Assistant Secretary of the Friends' Relief Mission in Vienna, writes that there are about 70 infant welfare centers in Vienna and 15 new prenatal clinics are being organized. These different centers are now joined in a central cooperating organization, through which they receive help from the Friends' Relief Mission. The whole of Upper and Lower Austria is covered with a network of coordinated child welfare centers.

The condition of the children, especially in the small industrial centers, is much worse than in Vienna, because they have not received the same aid. The willingness of the Austrian doctors and nurses to cooperate in every way has been most marked. Austria is doing her best to help herself with respect to her babies.—(*Maternity and Child Welfare,* May 1, 1921.)

American Relief Administration.—Quoting Sir William Goode, President of the Austrian Section of the Reparation Commission, *The Manchester Guardian* speaks as follows: "In the villages of the Styrian Alps I found proud abbots sitting on committees with anti-clerical butchers and carpenters, brought together after centuries of class estrangement only by the common cause of saving the children, and only under the pressure of the American Relief Administration efficiency. . . . Out of discussions as to the distribution of the supplies there has come not only a mingling of the classes, but an unpolitical cohesion which may go a long way to solve the riddle of Balkan politics."

Russia

The budget of the National Department of Maternity Welfare for the last fiscal year amounted to 5 billion, 55 million rubles,—"a sum worthy of consideration, in spite of the great depreciation in the value of money."—(*Deutsche Medizinische Wochenschrift,* March 17, 1921.)

HEALTH POSTERS

An exhibit of the Friends' Emergency and War Victims' Relief Committee is being held in London, the most interesting child welfare feature of which is a collection of Russian posters. Partly because of the widespread illiteracy, the new health movement in Russia has had to rely largely upon propaganda by poster. The posters shown were collected from the walls of clinics for mothers and babies. A typical one is a picture of a row of books over a corresponding row of gravestones, the relative sizes of the books and the gravestones showing the relation between illiteracy and infant mortality. Another shows the relation of infant mortality to the seasons, and is a group of four trees in seasonal states of development, with four corresponding groups of crosses, the largest group being below the tree in full summer leaf. A set of posters with clock faces shows the regular hours at which babies should be fed.—(*Manchester Guardian,* May 23, 1921.)

Germany

Infant Welfare Appropriations—The main committee of the Reichstag raised the infant welfare appropriation for the current year from 500,000 marks to 2,500,000 marks.

The Bavarian budget for 1921 provided five million marks for welfare work with infants and little children, measures against tuberculosis, venereal diseases and alcoholism. The amount specified in the tentative budget was 590,000 marks.

Books for Fathers and Mothers on the Health of Children

(The following list of books, and of comments thereon, has been selected from the list edited by Dr. Dorothy Reed Mendenhall and Miss Bascom, which was published by the Council on Health and Public Instruction of the American Medical Association, under the title "Child Welfare".)

GENERAL HEALTH

Cabot, R. C., M.D.—A Layman's Handbook of Medicine, 1916, 523 pp. Houghton, $2.

Characteristics of diseases, suggestions for prevention and protection, and much practical advice, written especially for social workers' needs.

Winslow, C. E. A.—Healthy Living, 1917, 385 pp., Merrill, 72 cents.

HOME NURSING

Aikens, C. A.—Home Nurses Handbook of Practical Nursing. Second Edition, 1917, 303 pp., Saunders, $1.50.

The most complete work next to the manuals for the trained nurse.

CARE OF EXPECTANT MOTHERS

Slemons, J. M., M.D.—The Prospective Mother, 1918, 343 pp., Appleton, $1.75.

The best work on pre-natal care and confinement, well written and authortative, giving the information the educated woman or nurse desires.

CARE OF BABIES AND OLDER CHILDREN

Holt, L. E.—Care and Feeding of Children, Ed. 9, 1918, 215 pp., Appleton, 85 cents.

The best known standard work, written in form of question and answer. Fuller on feeding than any other.

Lippert, F. E., M.D., and **Holmes, Arthur, M.D.**—When to Send for the Doctor, 1913, 265 pp., Lippincott, $1.25.

Treats largely of infants' and children's diseases and habits. Good chapters on the causes of retardation and what to do before the doctor comes. Very well adapted to the needs of the average mother.

Morse, J. L., M.D.—Care and Feeding of Children (Harvard Health Talks), 1914, 53 pp., Harvard University Press, 50 cents.

Brief but good suggestions for the diet, clothing, exercise and sleep, and education of a child from one to six years old.

Ramsey, W. R., M.D.—Infancy and Childhood, 1916, 198 pp., Dutton, $1.25.

Good general guide containing the most necessary information on all subjects except pre-natal care. Especially full chapters on structure, growth and development, and on contagious diseases.

Terman, L. M.—Hygiene of the School Child, 1914, 417 pp., Houghton, $1.75.

Admirable work on the fundamental facts of a child's physical development. Contains what every careful parent wishes to know about the laws of growth, factors influencing it, disorders sometimes arising, malnutrition, hygiene of teeth, nose and throat, eye and ear, voice, etc.

FOOD

Abt, Isaac A., M. D.—Baby's Food—Recipes for the Preparation of Food for Infants and Children, 1917, 143 pp., Saunders, $1.25.

Mendenhall, Dorothy Reed, M.D.—Milk—The Indispensable Good for Children, 1918, 32 pp., Children's Bureau, free.

Discusses the value of milk in the diet of the growing child and the kinds that can be used for infants and young

children. Compares the methods of manufacture, composition, and nutritive values of condensed and evaporated milk and milk powder.

Rose, M. S.—Feeding the Family, 1916, 449 pp., $2.10.

Gives menus and nutritional requirements for all ages.

McCollum, E. V., and Simmonds, Nina—The American Home Diet, 1920, 237 pp., Matthews, $3.50.

Newest book on diet from Johns Hopkins University.

TEETH

Brackett, C. A., M.D.—Care of the Teeth, 1915, 64 pp, Harvard University Press, 50 cents.

Practical little book in the "Harvard Health Talks" Series.

Head, Joseph—Care of the Teeth, Everyday Mouth Hygiene, 67 pp., 1920, Saunders, $1.00.

POSTURE

Bancroft, Jessie H.—The Posture of School Children, 1913, 327 pp., MacMillian, $1.50.

Standard work on proper carriage of the body, how to correct poor posture, and the school hygiene of posture.

PLAY

Lee, Joseph—Play in Education, 1915, 500 pp., MacMillan, $1.50.

Purpose of the play instinct; its relation with teaching, gymnastics and work; play psychology at different ages (four periods from one to fourteen); types of plays preferred and their educational significance. Very readable, useful to teachers and educated parents.

Recent Literature on Mother and Child Welfare

Bibliography

America

A Digest of Programs of National Organizations Carrying on Some Phase of Child Welfare has just been issued by the American Child Hygiene Association. Price $1.50 a copy.

"AVERAGE HEIGHTS AND WEIGHTS OF CHILDREN UNDER SIX YEARS OF AGE"

As a result of the "weighing and measuring tests" given during the Children's Year campaign of the Children's Bureau, over 2,000,000 records were made, showing the height, weight, age, sex, and race of each child examined, some particulars of his physical condition, and the country of birth of his father and mother. A careful selection was made of the records which could properly be used in preparing tables showing the average heights and weights of normal white children of the United States, under six years of age. These were tabulated in accordance with recommendations made by expert anthropologists, statisticians and pediatrists, and the tables are now made public. The children included in the tabulation were from every part of the country and from various racial stocks, 70 per cent being of native parentage. The averages for white children of native parentage agree very closely with the average for all white children.—(*Children's Bureau Community Child Welfare Series No. 2, Government Printing Office.*)

Books

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The Re-Establishment of World Energy

Livingston Farrand

The Europe of today is engaged in struggle for the survival of its civilization. We in America are inevitably involved in that struggle. * *

The European child has been subjected now for six years to prolonged malnutrition.

We have in Europe today no less than eleven million war orphans. There are still more who are not orphans but who have been subjected to an equal degree of distress and lack of care as a result of hostilities.

Lack of development, both physical and mental, lack of training and care inevitable under the circumstances, is producing a generation to which we must look forward in the next twenty years as that upon whose shoulders the civilization of Europe must rest, and the prospect is not re-assuring.

As a nation, we cannot stand aside, and unless we accept responsibility and fully and freely do our part, disaster is inevitable.

Excerpts from the Commemoration Day Address, The Johns Hopkins University, 1921.

MOTHER AND CHILD

A Magazine Concerned With Their Health

VOL. II SEPTEMBER, 1921 No. 9

Rochester's Equal Chance for All

The Practice of Preventive Medicine

Albert D. Kaiser, M. D.

A RECENT survey of the children of several schools revealed the fact that in a large school in the foreign population only eight per cent of the children had received the benefit of a tonsil-adenoid operation while at least thirty per cent were in urgent need of such an operation. In a private school in the same city fifty per cent of the children had received the benefits of the operation and only three children out of two hundred were in need of it. Further investigation in this community confirmed the belief that preventive measures, which are generally accepted as essential to good health, have been freely advocated but no provision made to carry out a program whereby all in need might profit. The most common complaints among young children are diseased tonsils and adenoids, decayed or misplaced teeth, and malnutrition. These defects, regardless of severity, form the groundwork for acute infections and chronic diseases. Merely to advocate care of the teeth, removal of diseased tonsils and adenoids and increased diet fails in most instances unless adequate provision is made for the correction of these defects. Child welfare stations have been a great adjunct to preventive medicine but so often examinations are made and advice given which cannot be followed. If deformities are to be corrected and chronic disease prevented the measures which are conceded to be helpful must be made available for all.

OVERCROWDED REPAIR SHOPS

The modern hospital is overcrowded, being obliged to turn away many sick persons. The average dispensary does do excellent preventive work but is limited to relatively few. Statistics prove the value of these preventive procedures. To assure progress in promoting better health in late childhood

The Tonsil and Adenoid Clinic.

and adult life communities must recognize the need for increased facilities to care for the child.

Every community appreciates its shortcomings in properly handling remedial measures. Physicians and nurses often say: "If we could only get caught up and adjust the needs of the neglected children it would be a simple matter to care for the defects that would develop with each new group of children." But to "get caught up", so to speak, seems so hopeless that no definite plans are made to treat all the children in a new generation.

Great stress has been put on repeated physical examination and literature is distributed freely on preventive measures. Most communities have good hospitals, dispensaries or welfare stations. Those who attend these institutions are benefitted. The parent who is interested enough in his child to have a periodical medical inspection made receives advice, but the great mass of people do not reach these institutions or physicians unless disease forces them to go. Progress will be slow unless remedial and preventive measures are not only offered to all but machinery is placed in motion that will bring to every parent's attention the responsibility towards his or her children. Our institutions to do prophylactic work must be able to handle all the prophylactic work.

In Rochester, a far-sighted layman who has in many ways been a benefactor to humanity failed to see why preventive and remedial measures should be only for those who sought them. He believes that if prevention has any virtue it must be universal. If one child can have the benefit of prophylactic dental care the community owes it to all. If tonsillectomy is a good operation for one potentially diseased child it should not be denied to two-thirds of our children. If nutrition classes with dietary increases are available to a few scattered here and there, why can't all under-nourished children have them?

Not only did he give of his substance, but his influence has been used in the community to make it everybody's business to make all children fit. He established the wonderful Dental Dispensary which, with its activities in the schools and main dispensary, examines and keeps in the best possible condition the teeth of the entire school population. Mr. George Eastman has enlisted the cooperation of all the hospitals in establishing a large Tonsil and Adenoid Clinic where under the most favorable and scientific conditions the children with diseased tonsils or obstructive adenoids are operated on. One hun-

dred and twenty-five cases a day are treated and every child is followed up to correct any other remedial defect. Not a child in Rochester will fail to have an opportunity for these preventive measures. The nutrition class training has been adopted bv the Board of Education as essential to mental development. Nutrition classes are conducted in all schools. The slogan in Rochester is: "An equal chance for all", and combined efforts to place these accepted preventive measures within the reach of all will reap its harvest in years to come.

Teaching preventive medicine must go on, but to practice these teachings is more essential, and not until this practice becomes universal in a community will the ideal state be approached.

The Dental Dispensary

Harvey J. Burkhart, D. D. S.,
Director

The Rochester Dental Dispensary, founded by Mr. George Eastman, was primarily for the purpose of proving out something in preventive dentistry. The economic phase of this question, the permanent good that may come to future generations by the education of children, from early childhood, in the value and necessity of proper attention to their teeth, and health conservation, were thoughts uppermost in his mind.

The Rochester Dental Dispensary

Mr. Eastman erected and equipped the building at an approximate cost of $400,000 and has provided an endowment of $1,800,000. Conditional upon the making of this gift were the requirements that

twelve of the leading business men of the city should become interested in this institution, by serving upon the board of management and contributing $1,000 a year each for five years, and that the City of Rochester should agree to appropriate the sum of $20,000 a year for five years to pay for the cleaning of the teeth of the children in the schools and orphan asylums. Both of these conditions were at once met. The first five years having expired, the trustees have renewed their pledge for another five years.

THE DISPENSARY MANAGEMENT

The Dispensary is managed absolutely by the Board of Trustees, and at no time in the future will the municipality of the city of Rochester have a voice in its management, so that none of its activities will be changed or interfered with by the various political and other changes that occur in the administration of municipal affairs.

There is a Social Service Department connected with the institution that supervises the admission of children for treatment. Eligibility for treatment is based upon the weekly income of the family and the schedule is as follows: 2 in family weekly income of $20.00; 3 in family weekly income of $27.00; 4 in family, weekly income of $32.00; 5 in family, weekly income of $35.00; 5 or more in family, $7 per person a week. If the income is greater than the maximum allowance, children are denied the privileges of the dispensary and are required to employ a regular dentist. A charge of five cents each visit is

Dental Hygieneists at Work in the Dispensary

Dental Hygienists in the Schools

made for the double purpose of teaching the children that the service is worth something, and also to make them feel that they are not being pauperized. The five cent charge is waived if a child is unable to pay it. Only children up to the age of sixteen are received.

THE TYPE OF WORK DONE

The usual dental operations are performed, consisting of filling, extracting and orthodontia or tooth straightening. These departments are all in charge of experts. There is no free service in the institution, and all of the work is done by graduate dentists. It is the aim of the dispensary to provide the best obtainable skill in the doing of children's dentistry. Since the establishment of the Dispensary, something over 20,500 patients have been treated and there have been 185,191 visits.

In the orthodontia department, there are about 150 cases under treatment. The results of the work in this department have been most gratifying, and the appearance and comfort of many children have been greatly improved. In many cases a noticeable improvement in speech has been observed, due to the widenening of the arch, and not infrequently children below normal mentality have been greatly helped by the removal of nerve pressure usually found in a crowded jaw.

After dental operations have been completed, a survey is made to ascertain if the child has enlarged or diseased tonsils and adenoids, in which case he is referred to the surgical department, where 3242 operations have been performed since the opening of the dispensary. Remarkable results have already been observed in the greatly improved condition of the children who have undergone these operations. It may also be said that there is no part of the work of the dispensary that has been more generally appreciated by parents than the splendid results in the nose and throat department.

The prophylactic work in the public schools is done under the direction of the dispensary authorities. Squads of graduate dental hygienists, young women specially educa-

ted for this purpose, in charge of licensed dentists, do this work in the various schools and orphan asylums. A portable equipment is provided for this purpose. Visits are made to the schools and institutions twice a year, and last year the mouths of approximately 41,000 children were cleaned twice. There is also a lecturer employed to give lantern slide and other talks to the school children, on the care of their teeth and the value and benefits of a clean mouth. Last year lectures were delivered to 46,000 children.

The Board of Education, Health Department and other municipal authorities, the physicians, and dentists have cooperated to the fullest extent, and much of the credit for this work is due to their sympathy and support. Rochester people also strongly support this work.

The education of the public in the tremendous advantages that come from a clean mouth and good teeth has been most helpful in obtaining the splendid results to be observed in Rochester. The general hygienic condition of the school children has noticeably improved. In many cases the children's appreciation of the comfort and benefit of a clean mouth has resulted in an improved condition in other directions. There has also been observed a wonderful improvement in discipline. Principals and teachers have stated that if this work had accomplished no other result than that of improving the childrens' dispositions, it it well worth the price.

What a Tonsil and Adenoid Clinic Means to a City

George W. Goler, M. D.,
Health Officer of Rochester

Ever since men began to live together a large part of man's energies has been expended in defending his body against disease. The closer man lived the more numerous his enemies, the more bitter the battle for health. Plague, typhoid, dysentery, diarrhoea, tuberculosis, pneumonia, hookworm, whooping cough, measles, scarlet fever, diphtheria and other infections,—now more than half of them preventable by vaccination, by sanitary measures, or their combination, — these were man's enemies. His chief occupation was fighting for life against them, or for that measure of health which he might get when recovered from the wounds inflicted by these enemies.

Man began really to prevent disease in various ways. By vaccination against smallpox he has in a century converted most of the civilized world to the belief that pocks were unnecessary marks of civilization. Later he began to understand that he could not pour his sewage into his drinking water without seriously endangering the lives of himself and his children. A little later he found that flies, lice and bugs could not constantly live on his body without extreme danger from plague and typhus. Still later, he learned that mosquitoes brought to him malaria and yellow fever, and then he learned to drain his

swamps. More recently he began to find out that his wife and children and he himself were more frequently subjected to tuberculosis and pneumonia, when he did not give proper attention to air and food, rest and recreation.

It took man decades to learn these simple facts, and it took him almost as much longer to apply simple well-tried means for prevention. But while man had been giving serious attention to general hygiene, he had, until recently, been neglecting personal hygiene. Soap has so recently been brought into common use that even the "once-a-week" was often neglected.

Before the dental practitioner began to come into his own, he extracted teeth, made plates, then crowned and bridged teeth, but finally learned to preserve teeth by early fillings, to insist upon the use of the tooth brush and dental floss, until now the tooth brush is used night and morning and after meals and dental floss, at least once daily before retiring.

Before and After Corrective Dental Treatment.

But it was not enough to save teeth by cleaning and filling them; it was found that they had to be firmly set in well-formed jaws, in a well-nourished, well-formed body. A still further step was taken when man began to find that there was an existing relation between the jaw and roof of the mouth, the shape and symmetry of the nostrils, the set of the ears, the level of the eyes, when in short the whole symmetry of the face, including the

teeth was disturbed by certain malformations which began early in the child's life and had their origin in infected or obstructed adenoids and tonsils. These adenoids and tonsils not only distorted the face, they interfered with the growth and stature of the body and thus with the ability of that body to do useful work. Slowly, very slowly, knowledge began to come to both the dentists and the medical practitioner that large and infected tonsils and adenoids were responsible for disturbances of this kind and that they frequently caused enlarged glands, infected ears, with resulting deafness, and joint affections, misnamed rheumatism. And whenever a child becomes sick from a non-preventable disease, such as scarlet fever or measles, the large and infected tonsils and adenoids frequently cause the infectious disease to pursue a much more severe course.

ROCHESTER'S TONSIL CAMPAIGN

Now, if enlarged and infected tonsils and adenoids do only a part of the things which have been charged against them, it certainly means much for a city to have had 10,000 children separated from such infective and obstructive vestigial organs. It means better health for the child, it means better men and women. It means that these children have had an opportunity for better nutrition and more than all, it means that much otherwise wasted energy has been saved to the child.

Nutrition Classes in Public and Parochial Schools.

Ethel M. Hendricksen,

Director of the Tuberculosis Association of Rochester and Monroe County.

NUTRITION classes were organized for school children in Rochester, following an institute on the nutritional problems of children conducted from the first of November to the twelfth, 1920, by Dr. William R. P. Emerson of Boston. Membership in this Institute included twenty teachers, mostly health education teachers whose tuition was paid by the Board of Education; ten school nurses, whose tuition was paid by the Health Bureau, and more than seventy other persons, including twenty-three physicians.

The Institute was conducted under the auspices of the Tuberculosis Association of Rochester and Monroe County, which organization bore the balance of the expense not made up by the Institute fees. The Association felt the Institute to have been so far reaching in its results and so generally helpful to health publicity and general community health education, that a second Institute has been arranged and will be conducted this year from the third of October to the fifteenth.

Upon weighing and measuring a group of children from several schools it was found that Rochester was typical of the average city in regard to the condition of malnutrition among its school children. The average per cent found suffer-

ing from malnutrition was about 33 1-3. Children from the good American homes were found to have more malnutrition than children of the foreign born, and of the poor. Rochester, too, discovered that poverty alone was not the cause of malnutrition. However, it is significant to note that malnutrition was more easily corrected in the good American homes where the intelligent cooperation of mothers could be relied upon.

The department of Health Education of the Board of Education was selected by the Superintendent of Schools to have charge of five nutrition classes to be carried out in the public schools. At the end of the fall semester, the success of these five classes was such that ten others were authorized and two full time nutrition workers were employed.

RURAL AND PAROCHIAL SCHOOLS

With two other full time nutrition workers, the Tuberculosis Association was able to organize seven classes in parochial schools and three in rural schools. Thus, as a result of the Institute, twenty-five classes were formed, and nearly 500 children from the malnourished group were placed under definite instruction for the correction of this condition.

Later a class was organized by the Tuberculosis Association for such children as applied for work permits who were found by the Health Bureau to be ten per cent, or more, underweight for height. Also classes were organized in orphanages and during the summer at one Social Settlement.

When school was dismissed in June, the Tuberculosis Association opened a camp on Lake Ontario for twenty children from the nutrition classes who were "free to gain," and yet were underweight. As rapidly as these children came up to weight, or exhibited a tendency to gain in weight over a period of two or three weeks, they were discharged and others admitted.

MANY PHYSICAL HANDICAPS

The greatest handicap to the progress of the classes last year was the large number of physical defects encountered. Some children had more than one defect. Tonsils and adenoids were the chief offenders. In one class of 21 children, 19 had need of tonsil and adenoid operations. As a consequence a good part of the year was taken up in having these defects cleared up and there was not enough time left to show the results which the nutrition class could accomplish. The class gains at the end of the 20 weeks, however, averaged more than 200 per cent in every instance.

To obviate the handicap of physical defects for another year, the Board of Education had every school child weighed and measured before the close of school in June. The teachers were in charge of the work and handled the statistics in a uniform manner prescribed by the Health Education Department. The per cent of children found under-

weight for height was practically one-third of those weighed and measured. Letters were prepared for the parents of these children and a list of rules sent them setting forth a program of action for the home during the summer. It is hoped that every child in this group will come before a physician for examination and will have physical defects corrected before the opening of school in the Fall. With children "free to gain" it is believed that the condition of malnutrition in the majority can be cleared up prompt-

A FEW NUTRITION STORIES

A few stories of the children in the nutrition classes will illustrate the work:

Nicholas, a severe asthma case, lost ¼ pound in eight weeks. Under the tests given him he was found susceptible to goose feathers upon which he was sleeping. His bed was changed, and in the two succeeding weeks he gained 2½ pounds.

Elmer gained 1¼ pounds in seven weeks before having tonsils removed and 6¼ pounds in seven weeks after the operation.

Laura made no gains for 12 weeks. She had a tonsil and adenoid operation and gained 3¼ pounds in 17 weeks. This was not satisfactory progress. She was removed from her home where her father and mother had no control over her, allowing late hours and other harmful practices. In the nutrition camp she gained six pounds in three weeks and was graduated.

Some children were found to be carrying programs of activity so great that no break was allowed between an early breakfast and supper at night. Even the noon lunch was taken on the run. Piano lessons, special religious instruction, outside work, such as paper routes and the like were all discouraged by the nutrition class physicians. Children in the nutrition classes were urged to make a business of getting up to weight and were then promised they could take up anything outside they desired.

Struggles were frequent with churches, schools and homes, all of which were competing for the child's time for extra activities outside the school. When the right person was interviewed and convinced that the child's health was at stake, programs were re-adjusted. This required much time on the part of the nutrition worker.

Credit for nutrition class work will be given by the Rochester Public Schools next year for the first time. New report cards just issued carry the space for this credit. Dr. Emerson is especially happy over this evidence of the keen appreciation of the Rochester Board of Education of a fundamental health problem. Dr. Herbert S. Weet, Superintendent of Schools of Rochester, states that the nutrition class has its chief value in the cooperation it provides between the home and the school. The class requires the full support of the home in carrying out its work. If parents will not pledge their cooperation the class abandons its work with the particular child in question.

The cost of the nutrition class

work has been estimated in different ways. The Tuberculosis Association in Rochester has found that $150 will carry a class through twenty weeks. This expense is divided as follows:

Supplies (.40 each for 20 children)	$ 8.00
Salary nutrition worker (rate $100 a month 1 day a week 20 weeks)	76.80
Transportation	10.00
Physician ($2.00 a visit 20 visits)	40.00
Supervision	15.00
Total	$149.80

The cost of supervision is a more or less variable figure. The Tuberculosis Association has employed a supervisor on part time, but expects to need the full time of a supervisor in another year. The services of Dr. Emerson and his head clinic worker, Miss Skilton, of Boston, are retained for quarterly visits during the school year. The Association has been paying for this service, almost wholly, although it is distributed among the twenty-five classes in operation. This service has not been included in the above estimate of the cost of maintaining a class.

Protecting the Health of Boarded-Out Children

Horace H. Jenks, M. D.

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THE child taken from its home for any reason and placed with a foster mother, is to my mind deserving of the most careful thought, not only as to the character of the home into which each special child is to be placed, but as to its physical care after placement.

There are two great and essential factors missing in the foster home—mother love, and home care. It is the function of the placing agency, through its social and medical departments, to supply, as far as may be, the care, and to so stimulate and train the foster mother that she will gradually attain an interest in the work and an affection for the children, which may carry the child along until the mother is again able to assume charge, or the child is possibly taken for adoption.

There are two main divisions in the work of placing out, sufficiently distinct medically to receive separate consideration, namely, foster homes for babies under three years of age, and foster homes for older children.

Under the best conditions, the life of the child under one year is difficult. Many dangers beset the newborn babe, and the mortality of the child under six months is still far too high. Consider then the added perils of the baby placed in a foster home, deprived of its mother's milk, and of the care, which except under the worst conditions,

is still preferable to that of a paid caretaker.

Previous to placement it is essential that the baby be given a thorough physical examination, and weighed entirely naked. The social worker should procure information as to the parents' condition, a history of the other births, still-born children, miscarriages and so forth. It is most helpful to know what milk mixtures the baby has recently had, and how he has reacted to them; especially what feeding the baby has had previous to his coming under observation, the number and character of the stools, the frequency of vomiting, and its relation to feeding. Accurate information upon these points will be of greatest use in determining a suitable mixture with which to start the baby's feeding in its new home. Breast milk is often desirable, but it is usually not obtainable upon such short notice.

The feeding in the foster home should be of the simplest character possible. If upon the first examination a baby is found to be so delicate, or so ill, that complicated feeding mixtures will be necessary, it is usually better to refer that baby to a hospital.

It is perfectly justifiable, and very often advisable, to perform the von Pirquet test for tuberculosis, or the Wassermann test for syphilis upon any baby with any signs or history of such infection in the family. A positive von Pirquet test in an infant under two years of age is almost certain evidence of active tuberculosis.

Again there should be the closest cooperation between the social worker and the doctor in the placement of these babies, and to place any baby, or for that matter, any child in a foster home without due regard to the medical findings, is most unwise, and indeed is properly looked down on by any good child placing agency. To place a sickly vomiting baby with a new and untried caretaker, or a nervous child on the verge of chorea, with a high-strung, neurotic woman, can result only in disaster.

REQUIREMENTS OF A FOSTER MOTHER

There are foster mothers and foster mothers. For our baby work there must be homes, not too far removed for close observation, preferably where the woman has had children of her own, and yet is not averse, nay is eager, to absorb the ideas of the medical staff, and is willing to cooperate in every particular. Most foster mothers are too impatient about the weight of the babies. To satisfy them the baby must gain by leaps and bounds.

Of course the foster mother herself should be healthy, and the home clean and neat. The goal to which we should work should be a complete physical examination of the foster mother, including a Wassermann test, but all of you who have attempted to find homes at all and know the difficulty thereof, will realize that this is not at

present practicable. The foster mother should be of reasonably good mentality, not necessarily a student or a genius, but equipped with a mind fairly evenly balanced, so that she will not give way to fits of anger; self controlled and patient, so that she is willing to submit her opinions to those of the medical staff; observant, that she may detect the early symptoms of any illness; and conscientious, that when alone with the baby she will do as she would when the nurse is watching her.

HOME EQUIPMENT AND CARE

Every baby foster home, in which there are difficult feeding cases, should be equipped by the society with arm balance scales, these scales remaining the property of the society. The babies should be weighed and a report given either in person, or by telephone, to the Clinic at least twice weekly, and the caretakers should be instructed in the need of weighing at the same hour and always with the same clothes (or lack of clothes).

Older babies, and those more easily fed, should be visited by the nurse weekly, or every two weeks. The weight may be taken on a portable spring scale, a record made of the character of the stools, the appearance of the baby, chafing or irritation beneath the diaper, and so forth. These reports should all be considered at the weekly "baby conference" held by the physicians, social workers, and nurses.

The foster mothers should, of course, all be carefully instructed as to the detection and meaning of the ordinary danger signs of illness in the baby, and they must always report the same to the nurse at once and the baby should be visited as soon as possible. These signs are marke loss of weight, fever diarrhoea, abnormal stools, unusual vomiting, palor, drowsiness or depression, and any skin eruption.

PREVENTING NUTRITIONAL DISEASES

Three of the great enemies of infancy, syphilis, tuberculosis and rickets, must always be watched for. The pain caused by the withdrawal of blood for the Wasserman test for syphilis is but temporary, and soon forgotten. It is certainly much less disturbing in infancy than in later childhood, and should never deter us from taking blood from the child whenever there is the slightest suspicion either in the appearance or in the history of the child. The von Pirquet tuberculin skin test is still more easily applied, and totally devoid of danger. The information derived from each test is always important and may be life saving.

The prevention of rickets in the colored or Italian babies is often difficult, and the cure still more so. We have believed that in addition to the cod liver oil, so clearly shown by Hess of New York to be the best preventive and remedial agent, the use of vegetable soups made from peas, beans, carrots, potatoes and so forth, is of distinct benefit, and they may often be given

without harm after the age of five months. Printed directions for the preparation of each of these soups are given to the foster mothers.

Every child of any age coming into the care of a Society for placement with a foster mother should have a Schick test for the determination of immunity to diphtheria. Those over the age of six months showing a lack of their natural immunity should be immunized by toxin-antitoxin, and the danger of diphtheria in foster homes can be absolutely eliminated. Infants in a foster home in which a case of whooping cough appears should at once be protected by pertussis vaccine, and in the great proportion of cases they will not contract this disease, so serious to infants. Girl babies should always be carefully examined for vaginitis before placement in a home, and it is safer and more satisfactory in every way to make careful microscopic examination for gonorrhoea. The record may be of value if the baby should later develop a discharge.

It is surprising how well babies will do in a carefully selected foster home, under careful nursing supervision. One important factor in our work is the weekly conferences between the social worker, the nurse, and the doctor. It is necessary to have all there. The nurse gives her accurate report, the doctor can decide what is best to be done, and the social worker, seeing all sides of the problem, suggests what she thinks is the best disposition of the matter, under the circumstances. It is most comforting to the doctor to work so closely in touch with the person who knows not only the conditions in the family under discussion, but who can decide at once whether there is any better home at present available for that particular child. For the more difficult cases it is almost a necessity to have available a foster home in charge of a woman experienced in the care of infants, preferably a trained nurse.

CARING FOR OLDER CHILDREN

Older children in the foster home need the same careful supervision and the same close coordination of medical and social work as the babies, but in a somewhat different manner.

The question of moral conduct begins to complicate matters, and this may, or may not, have a physical basis. Skin conditions, such as scabies, pediculosis (either of the hair or body) must be watched for; the child must be trained in what might be called the essential moralities; he must attain control of the bladder function; he must keep himself passably clean, and so forth. The question of scabies in the foster home is often a puzzling one to children's agencies. Children with scabies should be isolated at once from other children and all their clothes, including bed linen, towels and so forth, should be thoroughly boiled, preferably in the home, and not sent to the public

laundry. It is far better, if possible, to remove children with scabies to a foster home reserved for such children, and under the care of a woman especially trained in such care.

Children between two and three years of age should be observed at least once a month by the trained nurse, unless the foster mother is sufficiently intelligent to make satisfactory reports to the Clinic as to the children's general condition. Children from this age to six or seven should be seen every three months and children or adolescents of any age above this should have a complete physical examination at the Clinic at least every year. Those children 7 per cent below weight should be seen oftener, at least every six months, and those 10 per cent or more under weight, or in whom for any reason there is any suspicion of ill health or tuberculosis, should be seen and thoroughly examined every one or two months or oftener.

The undernourished child in the foster home presents a serious problem and one always calling for the closest team work between the medical and the social factors.

The medical examination, when the child first comes under the care of an agency, should be complete, and all facts recorded for future reference. The weight of the older children should always be taken without coat or shoes, and weight and height recorded at each regular visit. The weight to height ratio will be found more satisfactory than the weight to age, except where the child is evidently over, or under size, and it is advisable to state in the history card both the number of pounds and the percentage under weight. The printed cards issued by the "Nutrition Clinics for Delicate Children" of Boston will be very helpful.

A most watchful eye should be kept on any child 10 per cent or more under weight, and he should be brought to the Clinic again in a month, to be weighed and examined. The fact of this underweight should always be brought to the attention of the social worker in charge of placing out, so that she may arrange for such a child to have special diet, extra milk, a home in the country, and what is of almost equal importance, sufficient rest.

Doctor Emerson, of Boston, among others, has so clearly pointed out that what many of these chronically tired, anaemic, underweight boys and girls need, is not only good, properly cooked foods, and fresh air, but rest. It is often advisable to specify the number of hours of rest which a child should have, and when these rest periods should come.

In a child with no evidence of chronic disease such as syphilis or tuberculosis, it has at times seemed to me that the weight record may be a partial check upon the foster mother. It is by no means conclusive, but it should at least call

for thought and examination if successive children lose, or fail to gain, in weight in a certain home. We should regard such a home with a questioning eye, and should investigate without delay the factor entering into home hygiene, the food, the amount of time out of doors, the night ventilation, the utilization of the milk ordered, the life of the child in his hours of recreation. The food may be ample, but is it properly cooked, or floating in grease? Is the child getting that great destroyer of a child's appetite, candy, between meals? Does he have his afternoon rest, and then sit with the grown-ups for an evening movie? Those are but a few of the factors needing investigation by the social worker, and then correction. A nurse well trained in practical dietetics, or a visiting dietitian (such as is now available to some of the hospital nutrition clinics) is of the greatest value, to actually show these foster mothers how to properly cook food for young children.

PRINTED DIET INSTRUCTIONS

In the Children's Bureau we have found it helpful to have printed diet lists for children; definite printed directions for the cooking of the vegetable soups, whey, even barley water for the babies, and diets for children from one to three or four years of age.

The medical examiner should ever be on the watch for early signs of mental stress in the children under his care. This has been a field much neglected in the care of foster children. The early years in school for a child unfitted mentally for his tasks may cause him intense unhappiness from the ridicule of his fellows, and form the basis of moral delinquencies, or mental disease, in later childhood. The perplexing questions of adolescence may easily disturb a too sensitive nervous system, and may be the starting point of a later dementia praecox. How much better for the child and more satisfactory for those in whose care he is, to have the cooperation and help of a well trained psychiatrist to examine and test the various factors making up his mentality—memory, observation, concentration, originality and so forth, and to determine how fast and how far it will be advisable to go with that child, as well as to find the origin of his worries by delving into his mind.

It must be evident, therefore, that the problem of the care of the needy child in the foster home is one more complicated and needing more care than that of the child in his own home. The social worker in charge of placing out and the doctor who examines the child, must do close team work. The suggestion that the doctor makes as to treatment, diet, care and so forth for a special child should all be considered in determining upon a home for him and it is properly a function of the worker to see that the doctor's instructions to the foster mother are carefully carried

out, and that the child reports for observation at the specified time

On the other hand, the doctor must welcome suggestions from the trained worker. She may unearth in the family history something that may easily demand a Wasserman test, where clinical signs are lacking, or supply information suggestive of a bad mental or nervous ancestry. The doctor cannot be too insistent on the kind of home in which he should like a child placed. Such a home may not be immediately available. But if he finds a child obviously losing his health in a foster home in which, upon examination, the conditions are found unsatisfactory, his request for replacement should be carefully considered. It is only by the closest cooperation between the social worker, the physician, and the nurse that the best results can be attained in placing out and caring for the needy child in a foster home.

The Next Step in a Health Program

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WHEN we realize in America that the real prosperity of the country depends in large part upon the health, intelligence, and contentment of the average citizen, and that the greatest of these is health, it will not be so difficult to secure community action in bringing about those conditions known to be necessary for improved public health. Apparently progress must be made slowly. It is, of course, wise to continue with those national and local measures in all departments of public health which are gradually affecting opinion. But the time is now ripe to take another forward step by making actual demonstrations, in various limited neighborhoods, of what may be accomplished in lowering morbidity and mortality records, and in improving health conditions generally, if better sanitary standards are supported and carried out by the communities as a whole.

It is felt that if the actual demonstrations can be made over a term of years in an average community, many other sections will desire similar benefits and will be willing to pay the price. No price is too great for a community to pay for good health. The loss to the world through the early death, and the damage by disease of useful men and women is incalculable, and greater still has been the loss, or the failure to live, of unborn and new-born potential workers and thinkers. It is impossible to realize how many there are today in the world living in wretchedness and fear from ill health.

The civilized world was startled by the disclosures of the records of the young men examined for participation in the world war. In this

country, of the two and a half million men examined, out of every thousand there were 468 found to be defective, and 30 per cent were physically unfit for any military service. It was shown too, that fully half of these defects could have been prevented, or corrected, had they been attended to in childhood and had each individual been trained in proper habits of personal hygiene. When we consider that those two and a half million men were selected from the most vigorous period in life, we can form some conception of the larger proportion of our population older in years, in whom the multitudinous disabilities due to disease and age are added to the defects shown to be present in youth. Surely no demonstration could be more complete of the need of the American people for education in matters of public health; no subject should so challenge the attention of every physician and every agency concerned with the physical well-being of the people.

We are a life-masting people. During the year 1917 approximately 1,500,000 persons died in the United States, and it is believed with good reason that 42 per cent, or 630,000 of these deaths could have been prevented. What is needed therefore, is by every means to bring home to each man and woman in the country that a high degree of physical and mental health is an irreducible requirement for a people's prosperity.

Our army and navy lost less than 50,000 men through combat in the world war. In the same period, there occurred in the country twenty times that number, or 1,000,000 deaths from causes that were preventable or postponable. Is it possible that the same cooperative efficiency between the government and the caricatured "common people" which provided the tender care of our sick and wounded young men in the army should not be extended to the much larger number of our people ill and dying in civil life?

Is it not the time to take a somewhat broader view of health administration? Radical measures can alone hope to cope with such deplorable conditions. Most of the so-called health legislation, from the earliest times to the present day, has been concerned with the correction of well-known sanitary imperfections, rather than with the direct prevention of diseases and premature death. Practically all that has to do with the health of the individual, and his, or her physical well-being is still considered largely a matter of personal concern only. Many believe that a national health administration in the future will be devoted primarily to the task of supervising the growth and development of the nation's childhood, continued through the period of early and late adolescence, inclusive of the entrance into industry, or into other pursuits and activities.

In 1904 a report was made to the British government on the subject of the physical deterioration of the people. Among the principal recommendations were these: that there should be made an anthropometric survey, including the periodic examination and measurement of children and young persons in schools and factories, and also that there should be a registry of sickness, not confined to infectious diseases. If these recommendations had been seriously acted upon, who can doubt that the revelations of the war examinations in England would have been materially modified.

GREAT BRITAIN'S LESSON IGNORED

Professor Keith, of the Royal Institute of Public Health, declared in 1918 that "if the health of the people had been looked after, we should have been able to put into the fighting ranks at least a million more men."

The effect of environment upon growing children has been repeatedly demonstrated—the probability of healthy development is often permanently shattered by unhygienic home surroundings before children begin to attend school. In an investigation of 73,000 children of Glasgow, Sir Leslie MacKenzie found that "at the age of five, the one-room boy weighs, on the average, 37.2 lbs.; the two-room boy, 38.6 lbs.; the three-room boy, 39.5 lbs; the four-room boy, 40.1 lbs. At age nine the corresponding figures are 51.4 lbs; 53.1 lbs.; 54.8 lbs.; 56.6 lbs. At age eleven the figures are 60.0 lbs.; 62.2 lbs.; 64.5 lbs.; 66.2 lbs. For height, the corresponding figures at age five are 39.0 ins.; 39.9 ins.; 40.7 ins.; 41.4 ins.. At age nine the figures are 46.5 ins. 47.6 ins.; 48.2 ins.; 48.9 ins. At age eleven the figures are 50.1 ins.; 50.9 ins.; 51.7 ins.; 52.4 ins. The heights and weights at the other ages showed a similar relationship. The figures for girls at the corresponding ages showed corresponding averages." Any thorough investigation of school children at present discovers physical defects interfering with their normal progress which have escaped detection till too late to be easily remedied. In other words, in the future a greater emphasis must be placed upon physical, rather than medical facts, and a more concerted effort made to ascertain and prevent defects in physical growth and development. Progress indeed is being made but slowly in view of the tremendous need.

THE HEALTH CENTRE

Up to this time however there has been lacking an actual demonstration of improved health methods made applicable to a large community. This seems to many to be the most feasible immediate step in public health activities, which is to be accomplished through the establishment of so-called Health Centres.

The term "health centre" is by its very nature difficult to define. Its organization and activities dif-

fer somewhat in accordance with the needs of the area it serves. In general it may be said that it is a place which combines the administrative health functions and other health promoting efforts of the community, and secures their effective coordination in the service of that community. It should be the means of securing community service in health. Already in America there are more than two hundred so-called health centres but few of them are complete or ideal in their administration. In order to carry out the plan there should be a physical headquarters, a health promoting program, a definite attempt to reach all the members of the community, preferably a political unit, and the coordination of all existing operating agencies, health and social. An essential feature is the keeping of reliable records so that the results obtained after a reasonable period can be tabulated and compared. As in all public health endeavor, this intensive program depends upon accurate vital statistics.

It is therefore desirable that a political unit, one or more wards in a city, or a town, or a county be chosen, of which there are already data as to sickness, births and deaths and so forth, for comparison later on that the results obtained in improved health conditions can be demonstrated.

As already has been intimated the list of activities undertaken through a health centre is a long one; no centre embraces them all or even a considerable proportion of them. Many of them are the usual functions of the Health Department or other governmental authority and would not be duplicated in an area where these official duties were being effectively carried out. There is nothing however, concerning the health and well being of a community which may not be undertaken by a health centre if there is need. Certain centres are securing accurate registration of vital statistics, the medical inspection of schools, general sanitary inspection, laboratory diagnosis, and are conducting health exhibits, classes in dietetics, domestic science and first aid; are maintaining a training school for nurses, well baby clinics, emergency hospitals, and operating rooms, a general public health library and museum, public baths and clinics in the various departments of medicine.

NURSING AND CLINICAL CARE

Two activities however, are emphasized in nearly all centres—clinics for the sick, and nurses for home visiting. These clinics may be conducted by hospitals already established, but the health centre correlates the work, and attempts to bring for examination and treatment all the residents of the specific area needing this care Two groups of cases have thus far received primary attention in most of the health centres already established—namely, infants and young

children, and those having, or having been exposed to tuberculosis, and the care of the former includes the whole range of prenatal supervision, advice and instruction to mothers, the care and feeding of babies, the provision of clean milk, supervision of the homes and surroundings, inspection of boarded-out children, hygiene of children before and during their school years, and all the usual activities associated with the conservation of child life.

Certain centres have laid especial emphasis on the establishment of clinics and the promotion of educational work for the control of venereal diseases. Again it has been occasionally found that mental hygiene clinics can be advantageously established in a health centre apart from a large specialized hospital. Health centres have been the means of establishing many dental clinics, a very necessary field yet so inadequately covered even when there is satisfactory provision in the clinical lines. Enough perhaps has been said to indicate the wide range of activities which may legitimately be carried on in these intensive endeavors.

To establish such a centre in certain backward communities would mean the undertaking through the centre itself of most of these forms of service. In other, particularly urban centres, where the health department and various hospital clinics and other medical and social agencies are active, the problem is one primarily of co-ordination, making the centre the substation of an active, alert and efficient health department through which there shall be a common and united effort to provide every dweller in the given community within function concerning healthful living, skilled medical oversight—the opportunity to live his life as free as possible from the handicaps of ill health.

THE EDUCATIONAL INFLUENCE

Without doubt the most outstanding function of a health centre is the dissemination of knowledge on matters pertaining to public health and personal hygiene. It is of course an aphorism to declare that if everyone knew the more important facts about hygiene and sanitation, and applied this knowledge, there would be little need for the public health work so essential today. Public health education is therefore perhaps the most pressing need, and this information should be distributed in many forms helpful to various elements in the community. The centre should become a familiar neighborhood station from which are dispensed the most constructive influences in the promotion of physical well-being. It should make available to all the best circulars, books, and pamphlets on the nature and prevention of different diseases; on exercise, fresh air, food, and the maintenance of bodily vigor. If possible, an auditorium should be a part of the health centre, of suf-

ficient size to accommodate an average audience assembled to attend conferences and lectures on health subjects. There should be provision for lantern slides, motion pictures, and so forth.

A health centre in a community already organized should be a place where all the medical and social activities of the community are thoroughly known and rated, so that directions can be given to inquirers concerning any desired service. Newspaper publicity is becoming more and more used by health centres, as a means of disseminating their propaganda. Printed publicity alone often fails to reach the goal, but when printed advice is personally explained in the home by health visitors it seldom fails to make a lasting impression.

THE RESOURCES OF THE COMMUNITY DEVELOPED

From the beginning in the formation of a health centre it should be the aim to develop the resources of the community itself and in building up the work every effort is made to interest and enlist local support Whenever possible, the leading citizens, both men and women in the community, are organized for specific work. The help of local physicians, social workers, and religious organizations is sought and utilized and the community itself is made to see the great value of the program which is offered. No large number of people can be made good and healthy and kept so by influences solely from without, but when they appreciate and are willing to work for the end in view, the result is assured.

In the establishment of such a centre the activities must be carried on with the approval and support of the health authorities; the the whole effort being to set up an ideal health administration for a limited area, and one should look forward to the gradual taking over of its functions by the health department supported by an educated public opinion. In fact, the object of the plan is to demonstrate the value of just these methods of living which an up-to-date health department advocates but as yet has not been able to secure.

It is equally true, however, that the assistance of various volunteer and private organizations and institutions having to do with public health are now essential to the successful carrying out of the program. In the history of sanitary and moral reforms the initial vision has been seen, and the pioneer work has been commenced, by individuals and voluntary organizations. The wrongs of slavery first burnt themselves into the soul of Wilberforce, the cruelties enacted in prisons aroused the righteous indignation of John Howard, and the cry of wounded soldiers stirred the sympathies of Florence Nightingale, and so it has been all along the line of human progress toward better things. Great souls and groups of volunteers have been the

pioneers, the skirmishers, even the shock troops, and public officials, health departments, boards of education, and what not, have slowly arrived on the ground and have undertaken to organize the territory already entered.

Perhaps more progress has been made in this intensive health project in the domain of infant and child welfare than in any other. But I know of no large community where such a plan reaches every baby.

WHAT ONE MAN DID

In order to point to a successful experiment in Child Saving (almost the only satisfactory one I am familiar with) one has to cross the water to the Village of Villiers de Duc at the foothills of the Alps near where General Foch made his headquarters during the first battle of the Marne. In this village when a certain M. Morel became Mayor in 1854 he discovered that for 50 years from 22 to 26 babies out of every 100 born had died under one year of age. He called his people together and showed them that they were more successful in raising lambs and calves than babies. He suggested a simple practical program which resulted in reducing the infant mortality between 1854 and 1863 to 15 per hundred. On the death of Mayor Morel he was succeeded by two other men in turn not interested in infant mortality, and the rate rose again to 30 per hundred. Then came a second Mayor Morel, a son, a physician, who devised a complete set of regulations for the welfare of the community which he enforced through his office. Every pregnancy was reported to him in the early stage. Breast feeding was encouraged for every baby. The Mayor's office was notified of every case of illness within twenty-four hours, and regular medical clinics were held and an abundant milk supply was made available. These measures, vigorously enforced, resulted in saving the life of every baby born in that village from 1894 to 1903. No mother died in childbirth during these years.

WE NEED MORELS AND BROADBENTS

The great need in American communities today is a reproduction of this experiment. To do this the sympathetic cooperation of the mothers must of course be obtained. The truth of the statement is demonstrated by the results achieved by the shrewd benevolence of that far-seeing and generous Englishman, Benjamin Broadbent, Mayor of Huddersfield.* In that English borough notification of births within forty-eight (48) hours was enacted and a pound was offered as a birthday present to every baby born in the district which attained the age of twelve months. The homes of the babies were visited,

*See article on this work by Mr. Broadbent in MOTHER AND CHILD, July, 1921.

personal letters of instruction were sent to each mother on the onsent of the diarrhoel season and of cold weather, and as a result fewer than half the average of infant deaths took place in the twelve months. The vital features of these humane endeavors in a special field are the securing of the interest and co-operation of every individual in need of assistance and the provision of just the kind of prevention and of remedial supervision needed.

A BALTIMORE PLAN

For a long time it has been the dream of a group of persons concerned with improving the health of this city to establish a Health Centre in Batlimore. In no urban community is there a better feeling of good will and cooperation among the various philanthropic organizations and between the members of the medical profession.

Connected with the medical schools and the School of Hygiene are just the experts needed to advise and direct activities along the special lines that should be followed. There are already established clinics in obstetrics (with prenatal visiting), pediatrics, venereal diseases, tuberculosis, medicine and surgery, and clinical laboratories, of various kinds, all under competent direction. There are school physicians, and nursing organizations, for the nursing care of the sick, and for the child population, all doing splendid work. We have an efficient and forward-looking Health Department in full sympathy with the plan.

All these agencies together are at present by no means reaching satisfactorily all the people defective or ill, and Baltimore has morbidity and mortality rates perhaps a little higher than other cities of its size. It is proposed then to take an area of the city, probably two wards, and to organize the available medical and social resources in a unified plan that in due time will reach every man, woman and child in the selected area. Information and advice on personal and public hygiene will be widely disseminated from a central office, which will be a kind of clearing house from which all applications will be directed to the proper clinic or agency for assistance. Additional public health nurses will be engaged to cooperate with those already in the field. Such an area will provide practical field work for students in medicine, hygiene, and social service which will prove invaluable in after years, and without which the most complete didactic courses must be insufficient.

It is believed that the cordial interest and support of the better element in the selected community can be secured, and that in a reasonable number of years, the value to the individual and to the community, accruing from a more vigorous physique, and better health will be conclusively proven, and that the expenditure necessary to obtain this result will be shown to be

negligible in comparison with the benefits received. If this proves true and Q. E. D. can be written under the proposition that such methods, plus such expenditures, equal a greatly higher average in physical condition, and a lowered mortality and morbidity rate for all ages—the cause of public health in America will have been furthered as is possible in no other way.

It is no wonder that the American Red Cross is interested in the program of establishing health centres. It ought not to be said, and it cannot be said, that this national organization which summoned under its standard practically the whole nation, is quickened to activity only by temporary calamities and remains unconscious of preventable disaster and death that gnaw at the vitality and prosperity of the people.

Ignorance is the cause of this condition, and health education is the great means of service by which this ignorance can be removed. The Red Cross seeks to transfer a large part of the activities of its 8,000,000 loyal workers during the war, its work in battle-scarred France where it helped the French mother to save her baby's life, and the French people to cope with disease, to strategic centres in our own country, where the same spirit will render to our own people the same kind of service which it gave so unstintingly to a foreign people. This is not the place to enter into the details of the organization of a health centre. I have tried to outline briefly the great need, and to indicate that to meet this real emergency, the most practical immediate step seems to be the introduction of such intensive methods of public and private sanitation as will reach 100 per cent of the population of a restricted area, that thus the efficacy of these methods will be proven, and if proven, reproduced on a large scale in areas less restricted.

The Twelfth Annual Meeting of the American Child Hygiene Association

THE forthcoming Annual Meeting of the American Child Hygiene Association will be of unusual interest. The program is promising, and the people who are actually doing progressive work in child welfare will be there. Furthermore, the Association this year holds its birthday celebration in the city in which it was born. The name of the Association was changed a few years ago. It began as The American Association for the Study and Prevention of Infant Mortality, which was a direct result of the Conference on the Prevention of Infant Mortality, held by the American Academy of Medicine in Yale University, November tenth and eleventh, 1909.

This year the meetings will be opened November second and continued through the fifth of November.

WEDNESDAY, NOVEMBER SECOND

On Wednesday morning the Annual Meeting of the Executive Committee will be followed by the Annual Meeting of the Board of Directors.

In the afternoon the topic for consideration in General Session will be the Coordination of Child Health Activities. Mr. Courtenay Dinwiddie, Executive Secretary of the National Child Health Council, will preside. Dr. Haven Emerson of New York City will present the matter of Local Coordination, discussion being opened by Dr. S. Josephine Baker and Miss Ella Phillips Crandall. Dr. S. J. Crumbine of Topeka will discuss State Coordination. The subject of National Coordination will also be presented.

In the later afternoon a visit to the Health Center of New Haven has been arranged.

In the evening the President, Dr. H. L. K. Shaw, will preside at the Annual Business meeting for members of the Association.

THURSDAY, NOVEMBER THIRD

Thursday morning at ten o'clock, Dr. Shaw will make his presidential address. This will be followed by the General Director's report of Progress in Child Hygiene Work in this Country. The affiliated societies will then present brief accounts of their work in answer to a Roll Call.

In the afternoon, Health Education will be discussed with Dr. Thomas E. Finnegan, of Harrisburg, in the chair. Mrs. Charles H. Remington of Providence will give a paper on The Home and Child Hygiene. Miss Julia Wade Abbott of Washington will speak on The Establishment of Health Habits in the Kindergarten. Mrs. Arnold Gesell of New Haven will present a paper on The Psychology of Health Education.

Dr. Frances Sage Bradley of the Federal Children's Bureau will preside at a Round Table on Rural Problems four o'clock Thursday afternoon. The first topic here is the Nutrition of the Rural Child. Dr. Ethel Watters of San Francisco will discuss the Period of Infancy, and Mrs. Ira Couch Wood of Chicago the Period of School Life. The County Centers will be discussed by Dr. E. J. Huenekins and Mrs. Ruth Dodd.

The Public Meeting will be held at half past eight Thursday evening.

FRIDAY, NOVEMBER FOURTH

There will be two General Sessions on Friday. In the morning session the Problems and Opportunities of Lay Directors of Private Organizations will be presented.

In the afternoon session, the subject will be The Child of Pre-School Age. Dr. William Palmer Lucas will preside. Dr. C. Macfee Campbell of Boston will read a paper on the psychology of this age.

The Directors of Divisions of

Child Hygiene have asked to have a special time set aside when they may discuss among themselves matters which concern them most. They will meet at ten o'clock Friday morning with Dr. Ellen C. Potter in the chair. The topics to be discussed are: (a) The Organization of State Division of Child Hygiene with Especial Reference to Emphasis by the Budget; (b) Relation of State and Municipal Officials Child Welfare Activities to Private Physicians; (c) Public Health Nursing in Relation to the Work of Child Hygiene Divisions; (d) Is a State or Municipal Official Prenatal Program Practicable, and if so, what is its Scope and Method?

There will be two General Sessions, one at ten o'clock in the morning and the other at two o'clock in the afternoon, over both of which Miss Sara B. Place of Chicago will preside. Volunteer Workers .s the subject for the morning session, and in the afternoon Miss Anne Sutherland of New York City will read a paper on Teaching Methods and Equipment in Health Programs for the Child under Six Years of Age.

In the evening there will be a meeting of the Board of Directors.

SATURDAY, NOVEMBER FIFTH

Dr. Edwards S. Parks will preside at the Medical Session Saturday morning at ten o'clock and read a paper on Nutrition. There will also be papers on Obstetrics and Posture in this Session, followed by clinics under the direction of Dr. Park.

Child Health Demonstration

City and Director Chosen

THE City of Mansfield and County of Richland, Ohio, have been chosen from the eighty cities competing for the demonstration in the field of child health, to be conducted under the auspices of the National Child Health Council.

Dr. Walter H. Brown, best known as Health Officer of Bridgeport, Connecticut, also distinguished for service in the Red Cross and later with the American Commission for the Prevention Tuberculosis in France, has been secured as the director for the demonstration.

Because of the desire of Mansfield's superintendent of schools for help in the extension of health education, it is particularly suitable that this demonstration will be launched early in the fall, thus fitting in with the school term.

The Council made a long and careful study of the relative merits of the cities seeking the opportunity of carrying out this program for child health. Mansfield and Richland County won its vote because they most nearly met all the requirements.

From the medical profession, business and labor, city and county officials, women's organizations, churches, civic and social organizations, led by the Chamber of Commerce, have come enthusiastic promises of cooperation.

It is believed that with this attitude on the part of the city and county and with Dr. Brown's proven ability in the health field, this effort of a community in behalf of its children promises well.

The New Haven Visiting Nurse Association's New Record System

Abbie M. Gilbert, R. N.
Supervisor, Child Welfare Department

A NEW record system has been adopted by the New Haven Visiting Nurse Association. There were three factors uppermost in the minds of everyone in introducing it, namely, statistical research, supervision of nurses' work with a view to improving the service, and reduction to a minimum of the amount of clerical work required of the nurse. It is conceded that the nurse should be required to obtain only the data necessary to the successful treatment of the patient, and to the carrying out of these factors.

The same forms are used both for the "generalized" work as carried on in the Health Center, and for the "specialized" work in the other departments.

When a call comes to the main office over the telephone, the following record is made:

> Name and address of the patient; floor code; age; diagnosis; orders; name and address of physician; name of person reporting the case; time of notification; name of nurse; date of visit.

This record goes to the registrar's office, the patient is looked up, and assigned to the proper department. If the patient has been nursed before, the nurse reads the old record before visiting the patient.

On her first visit to the home, the nurse fills out as completely as possible, the following history sheet:

> Patient's name and address (including city ward); policy number; agent's name or number; date of issue; color; sex; single, married, widowed, deserted; place and date of birth; length of time in the United States, and in New Haven; kind of work; where employed;
>
> Length of illness—up and about, in bed; diagnosis; doctor's orders; name of doctor; name of person reporting case;
>
> Home conditions—clean, fair, dirty; roomers—male, female; church; known to other agencies;
>
> Name of wife, or mother; her birthplace; occupation;
>
> Name of husband, or father; his birthplace; occupation;
>
> Names and dates of birth of children.

This is brought to the registrar who makes patient's cards in duplicate. This record is the same in form as the history sheet, except that the patient's card includes the number and dates of the doctor's visits. One of the duplicate cards is kept on file in the office, and the carbon copy is given to the nurse.

If the first history is not complete, a partial history sheet, with the omitted items checked, is given to the nurse so that she may obtain the desired information on her next visit. The items on this partial history sheet are:

Nurse; address; policy number; agent; date of issue; date of birth; how long ill—up and about, in bed; diagnosis; doctor's orders; doctor; reported by; basis of payment.

NURSE'S COMPLETE RECORD

Each nurse is requested to carry her copy of the patient's card with her on each visit to the patient. The advantage of this is that the nurse has a complete record of her patient on each visit. On the back of patient's card space is left in which to note on each visit the condition of the patient, the services rendered, and remarks.

The nurse also takes to the home of each patient a daily report sheet, on which the nurse records these items:

Name; address; time of entering; time of leaving; fees; nursing visits; social service visits; advisory visits; not at home; office hours; carefare; new cases; discharges, name, address, condition, and to whom transferred.

To this daily report is clipped the cards of patients visited, and the whole is sent to the registrar.

After the information regarding patient has been transferred to the patient's permanent card, the duplicate copy is returned to the nurse. With cases requiring daily visits, the nurse retains her card, and reports to the registrar, on a plain slip, the services rendered daily.

The daily report sheet and the patient's card are the only daily record keeping the nurse does.

In the Child Welfare Department, another card is used, on which is charted the weight of the baby and its feeding. This form is written once a week, and kept in the weighing station.

The registrar keeps an index of all patients, with name, address, date of admission, department case number, and date of dismissal. She also has a monthly report form which shows:

Patients discharged; condition on discharge; to whom transferred; the number of patients classified according to diseases, age periods, residence by city wards; nationality; agencies or persons reporting; basis of payment.

USEFUL SUMMARIES

The registrar gives each supervisor a summary by districts of the work done in each department, for the month. This summary is posted on the bulletin board. Each nurse may see at a glance a summary of the work done in her district.

The nurses have liked the new system very much, except that they have found some difficulty in writing the record in the home. We have asked the nurses to do as much of this as possible in each patient's home, and hope for better results.

We feel the amount of time spent by the nurses in record keeping has been reduced to a minimum, and we have a much better record in every way.

MOTHER AND CHILD
A Magazine Concerned With Their Health

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SEPTEMBER, 1921

Hail and Farewell

Miss Julia Lathrop has resigned as chief of the Children's Bureau in the Department of Labor, and President Harding's appointment of Miss Grace Abbott as Miss Lathrop's successor has been confirmed by the Senate.

Miss Abbott was born in Nebraska where her parents still reside, although she has spent recent years in Chicago. She is a graduate of the University of Nebraska, and of the University of Chicago. She has been director of the Chicago League for the Protection of Immigrants.

In 1917 Miss Abbott was appointed Director of the Child Labor Division of the Children's Bureau of the United States Department of Labor. Later Miss Abbott was an advisor on the War Labor Policies Board. She has come to know intimately the problems of child life.

Whatever her occupation Miss Abbott has always exhibited the same qualities of genuine democratic human understanding and keen intellectual discrimination.

Miss Abbott's appointment gives satisfaction to all who desire to see the scientific services of the Government developed, and who realize that this is only possible when these services are immune from political considerations and when they can secure the leadership of persons of fine scientific attainment and personal character. These qualities Miss Abbott combines in high degree.

Miss Lathrop's whole life has been spent in studying the matters of deepest significance to the well being of children. Mr. Robert E. Woods has spoken of her "historic national service in laying the foundations for the sound life and work of the coming generation."

Miss Lathrop is a pioneer. Largely through her efforts the first Juvenile Court law in this country went into effect in Illinois. Her interest in securing their rights to delinquent children was not keener than her sympathetic understanding of the needs of those who were dependent, or defective, or working under wrong conditions.

When the Children's Bureau was founded its first chief was Miss Lathrop. She has been fearless, undaunted, far-sighted;—"let her

own works praise her in the gates."

In her own words "the protection of childhood is costly. The standards we are willing to accept and carry forward are a test of democracy because they are a test of whether it is the popular will to pay the cost of what we agree is essential to the wise and safe bringing up of children."

In June Yale University conferred the degree of Master of Arts on Miss Lathrop, recognizing her as "a fearless humanitarian whose career is a public blessing."

Doctor Knox Appointed

Early in 1921 Dr. Farrand announced that in Europe a child welfare unit system was being put into operation, which would henceforth represent the chief Red Cross work there. In Austria it is planned to have possibly 100 child welfare units, 40 of these to be in Vienna and the remainder in the provinces.

These will be for the care of well children, as the machinery for the care of sick children in Austria is running fairly well. From 300 to 500 children will be cared for by each unit, follow-up work being done in the homes of the children.

In Vienna a school for health workers will be conducted, the course lasting three months, and covering both theoretical and practical work.

Dr. Kendall Emerson says that "the work in Austria is being carried out under peculiarly hopeful circumstances, the cooperation of the Austrian doctors being in the highest degree helpful."

Czecho-Slovakia is now divided into 21 districts in each of which the Red Cross intends to establish a model child welfare center. Subcenters under the government and local institutions will radiate from this model center through each district.

"While it was impossible," Dr. Farrand says, "to set up an absolute uniform standard, the needs of one country, or section, differing wholly from those of another, the general plan of each of these units provides for one or more doctors, and nurses, and a trained social worker.

Dr. J. H. Mason Knox, Jr., has been appointed by the American Red Cross to carry on this type of work for the millions of European children who are in dire need. Dr. Knox's article in this magazine shows not only the value of such work, but reveals his grasp of it. During the war he directed just such a piece of work in one section of Paris, demonstrating its worth. This work is still going forward there.

Dr. Knox was the first president of the American Child Hygiene Association, and all these years both he and Mrs. Knox have most generously furthered its aims and purposes. The Association bids them Godspeed.

The Day's Work

CANADA'S BABY SAVING TRAIN

The first health train to operate in Canada left Montreal August 7 for a month's tour of the Province of Quebec.

The Health Special is the latest attempt of the Montreal Child Welfare Association to stir the population of this section of the Dominion to make some attempt to cope with the mortality among young children in this province. The tour is being directed by the organization, but it has been endorsed and partly financed by the provincial Red Cross Association, and been made possible by the co-operation of the Canadian Pacific Railway. In order that the tour may have the best possible support, the assistance of the Social Service Departments of the University of Montreal and of McGill have been solicited, and each will send a representative to help in the work of spreading information on child health among mothers in over thirty Quebec towns.

The special consists of two cars, one tourist coach, which will be dismantled and suitably equipped entirely as an exhibit car, and a sleeper.

Booths will be constructed along the sides of the tourist car to demonstrate the care of the child up to the age of fourteen. The exhibits will include a pre-natal booth, the child at birth, the growing infant and the child at school, and mothers will be shown proper foods and methods of preparing it, and will also receive instruction in the general care of their children. Attractive posters will be hung up all over the car, and moving pictures will be taken from town to town to teach the same health lessons.

The second coach will be divided into two sections, one part as an examination and conference room and the other as living quarters for the staff, who will sleep and eat in the car.

Copious advance literature has been sent out. All propaganda must be bilingual, and this necessitates double work, as the literature to be distributed must be in both languages, while workers also must be able to converse in both tongues. It is hoped that considerable may be accomplished to rouse public opinion to conditions of infant mortality in the Province, where the death rate of white babies is even higher than the negro death rate in the United States, and almost twice as high as that of white children across the border.

MILWAUKEE'S RULING FOR BABIES

Dr. George C. Ruhland, health commissioner of Milwaukee, is credited with the statement that deaths of illegitimate babies have decreased upward of 50 per cent following the ruling of the Health Department that mothers and their

babies must remain together the first three months of the child's life.

"In 1917 a state bill requiring the mothers to keep their children six months was killed in the legislature. The Milwaukee ruling, a local one, was promulgated as a compromise."

The regulation has often been found to result in the mothers keeping their children permanently, says the doctor, and has greatly reduced the number of births of illegitimate children in Milwaukee. —*The Social Hygiene Bulletin for August,* 1921.)

PROFESSOR VON PIRQUET AT YALE

Professor Clemens von Pirquet, the leading authority in the world on the subject of the nutrition of children, has been appointed as lecturer on the Silliman Foundation of Yale University. Professor von Pirquet is professor of children's diseases in the University of Vienna. For seven years past he and his co-workers at Vienna have been occupied in studying the nutrition of children of all ages upon a quantitative basis. Recently, as commissioner of the American Relief Administration for America, he has had an opportunity of applying the principles arrived at in his investigations to the problem of communal feeding on a large scale. His lectures will be on the general subject of undernutrition, with reference to tuberculosis in children and its treatment upon nutritional lines.—(*The New Haven Journal Courier.*)

HOW CLEVELAND PREVENTS DIPHTHERIA

Dr. Gerstenberger of Cleveland says in *The Public Health Nurse*:

"The plan adopted by the Babies' Dispensary and Hospital, with the cooperation of the Department of Health, has as its basis the following ideas:

(1) To bring to the attention of the medical profession of Cleveland the importance of active immunization against diphtheria of all children from six months to six years of age.

(2) To place at the disposal of all the family physicians a reliable toxin-antitoxin mixture at cost.

(3) To interest the public in general in the importance of having the children from six months to six years immunized against diphtheria by their family physicians, and

(4) To actively immunize at twelve of the fourteen infant welfare stations of Cleveland any young children between the ages of six months and six years who have not been taken to the family physicians for the injection of the toxin-antitoxin.

"In order to make the most economic use of the time and, consequently, enable the vaccination of the greatest number during the period of forty-eight weeks, the twelve Infant Welfare Stations of the Department of Health, where the injections are made by a full-time physician, with the aid of a full-time nurse, both from the staff of the Babies' Dispensary and Hos-

pital, have been arranged in two groups of six. In the groups each dispensary has a different day on which the administration of toxin-antitoxin is performed. For instance, Dispensary No. 1 is utilized on Monday, No. 2 on Tuesday, No. 3 on Wednesday, No. 4 on Thursday, No. 5 on Friday and No. 6 on Saturday. This order is repeated in the following week, and in the third week. At the end of the third week the doctor and nurse visit the second group of dispensaries. In this group No. 7 is open on Monday, No. 8 on Tuesday, No. 9 on Wednesday, No. 10 on Thursday, No. 11 on Friday and No. 12 on Saturday, and the doctor and nurse again return to these dispensaries for a second and third week This order is due to the requirement of Doctors Park and Zingher that an injection of 1 c.c. of toxin-antitoxin mixture be made once a week for three consecutive weeks, and as just stated above, in order to bring the doctor and the nurse into contact with the greatest number of stations and young children, with the least waste of time. The response of the Infant Welfare Stations has been distinctly encouraging.

"A detail that has seemed to us of great practical importance in being successful in this attempt to have as many children as possible vaccinated by family physicians and dispensaries against diphtheria has been the decision to inject all children under six, without first performing a Schick test, even though they be of the ages from three to six years. Zingher suggests "Schicking" all children over three, but in a personal communication to the writer, Doctor Park gives gives his sanction to the plan of not using the Schick test in children under six.

"All children who receive three injections of the toxin-antitoxin mixture receive a certificate which may later be used when they enter school as evidence that they have been vaccinated against diphtheria. Such a certificate will, in all probability, avoid the necessity of having a Schick test performed at that time."

JOHNS HOPKINS LECTURES

Dr. Richard A. Bolt, General Director of the American Child Hygiene Association, will give a course on Health and Preventable Disease, with special emphasis on the care of the mother and child, as a part of the Courses in Social Economics offered by the Johns Hopkins University. These lectures begin October 5, 1921. Visits will be paid, under the supervision of Dr. Bolt, to Health Centers and Baby Clinics. Special courses are also offered in Psychiatric Social Work, General Medical Social Service, and Medical Social Service with Children. The courses in Social Economics are planned to equip students with the training necessary to equip them to take responsible positions in any field of social work.

For further information apply to Miss Theo. Jacobs, Johns Hopkins University, Baltimore, Maryland.

PROGRESS OF BOSTON'S BABY HYGIENE ASSOCIATION

The director's annual report for 1920 of the Baby Hygiene Association of Boston, emphasizes the growth of that Association since 1909. "In January of that year", Miss Rand says, "we supervised 218 babies, while in January 1921 we supervised 13,769 babies; and the Association, now about sixty times as big as it was twelve years ago, is experiencing that feeling characterized as "curiouser and curiouser" by Alice, as she felt herself stretching out to an apparently limitless height, with her feet so far away that she felt she must say goodbye to them.

"Why has the Association grown so? Because the mothers and babies of Boston needed the services which the ssociation prepared itself to give. Who wants ill-cared for, sick and dying babies and ignorant mothers? No one, and the mothers and babies least of all; and that is why the Association has been sought out more and more, and why we have been truly "advertized by our loving friends". Last year of the 7,272 babies and children who came to us for the first time, 3,751 came because their mothers were referred to us by the mothers of babies already in our care.

"We are providing trained workers, nurses, and dietitians, to visit in the homes for the welfare of the babies and little children. We are teaching the mothers the many details of right care for the babies; we are teaching the wise buying and preparation of the right food for children; we are teaching the right care of these often pitifully neglected and badly handled little children who are no longer babies but who are certainly in great need of careful attention. The child of three or four cannot be left to "just grow," like Topsy.

"In addition to the home visitors, the Association provides weekly conferences at the twenty-one welfare stations where physicians are present to examine the babies and, in ten stations, the children of pre-school age as well, and to give advice to the mothers in their feeding and care. One part of the work is as essential as the other. Home visiting and teaching without the background of the physical examination andthe advice of the doctor cannot be as effective or sound as it should be, for what "the doctor says" carries weight. On the other hand, the conference work without follow-up work in the home would also be ineffective.

"The great need now is for the babies and children who are not yet reached. Over 6,000 babies came to us last year but it is safe to say that at least 4,000 more might have benefited by supervision. Fourteen hundred babies had to be discharged when they were two years old because there were not enough workers to care for them. Of the approximately 75,000 children between the ages of two and

five in Boston, only about 2,200 were under our care. We are barely making a beginning in this field and the need is very great, judged by the work we have found to do with the 2,200.

"These services cost $6.71 per baby last year. Compare this with the total cost of remedial work! But in spite of the low per capita cost the sum total makes the support of such work a serious question for the public to consider. And yet can the public afford not to support it? For after all the chief business of the "grown-ups" is to safeguard the children.

"The mothers of babies have contributed over $2,200 to the work by becoming associaote members of the organization, and they have also assisted in local activities for the support of their particular station.

"During the year, Station Committees for as many stations as possible have been formed for the purpose of increasing the efficiency and activities of the stations, and also for the purpose of developing local support. The beginning made promises well for the future, for we must look to Community Support for a Community Need.

Dr. Richard M. Smith, chairman of the Board of Trustees, reports that "the work with infants has produced such satisfactory results in helping babies keep well and in saving lives that no radical change in method need be considered. It has been a real problem to provide for the number of new babies because our present staff of nurses already has as many as it can adequately take care of.

"The supervision of the older children from two to five years of age has been conducted in several ways, differing in different stations. The methods of work with these children are being studied carefully by the Association, as well as by others, to determine the best way to secure the desired result of having the children enter school without malnutrition or any other physical defects. The greatest emphasis is placed on nutrition, which is the basis of all the work. The need for continuing the work of the Association is obvious and the pressure for expansion is tremendous. The future well-being of the city is bound up in the health of the children."

CHILDRENS' COMMISSION OF OREGON

The Child Welfare Commission of Oregon is completing arrangements with the University of Oregon Medical School, for a clinic for dependent children who are wards of the institutions. Thorough physical and mental examinations will be made under the direction of Doctor Rosenfeld of the Commission, and Doctor Dillhunt, Dean of the Medical School. The defects found will be remedied.

A general survey of all dependent children in Oregon institutions is just being completed.

The Foreign Field

England

NATIONAL BABY WEEK

In announcing the advent of National Baby Week, the *Lancet* said: "the fifth birthday of National Baby Week, to be celebrated on July 1st and for a week thereafter, will again give to the nation an opportunity of considering the needs of its children, and the steps which are —or are not—being taken to meet those needs. Birthdays have their uses and not the least is that they serve as landmarks, from whence one can survey the progress made, or the ground lost, in the past years. In this fifth year of its existence of the National Baby Week Council, in common with other societies engaged in child welfare work of one sort or another, is able to rejoice in the decreasing infant mortality rate, the figure for 1920 (80 per 1000 births) being the lowest recorded. Many influences have contributed to bring about this satisfactory result, and the National Baby Week Council feels that it may claim a not inconsiderable share of the credit. Since the first Baby Week held in 1917, the Council has worked steadily to make known the position of child welfare in the country. Its work is wholly that of education and propaganda; it exists to draw attention to the child, its needs, its disabilities, and its possibilities. Each year the Council has concentrated on some particular aspects of child welfare, thus focusing attention on one or two important points, not suggesting that by so doing it has covered the whole field of child welfare, but rather excluding some important points in order that others may for the time being be emphasized. Thus, in its first year, attention was drawn to the facts of infant mortality, and the importance of infant life to a nation which was daily losing the flower of its manhood in the great war. In 1918, the teaching of mothercraft was the slogan; in 1919, the creation of new and better ideals of babyhood and the importance of natural feeding; and in 1920, the necessity for liquor control in the interests of maternity and child welfare, the better care of the unmarried mother and her child, and the urgent need for some scheme of pensions for civilian widows with young children.

This year the Council is emphasizing three matters of great importance, two of which have already been emphasized in previous years: 1. The importance of natural feeding, in view of the fact that a naturally-fed baby has twice as good a chance of surviving as the artificially-fed baby. 2. The urgent need for some scheme of pensions for civilian widows with young children, which will enable the children to remain in the care of their

own mothers, instead of being entrusted to the much more expensive care of public institutions. 3. The prevention of infantile blindness and the importance of notification and treatment of ophthalmia neonatorum. This year, too, as last year, the Council is identifying itself with the Children's Era Movement, which aims at the closer cooperation of all existing agencies for the betterment of the child—religion, health, recreation, education, and so forth. While the Council rejoices with other child welfare societies in the lowered infant mortality rate, it realizes that in success there is an element of danger. Those who care for the children of this nation must not be content with this lowered rate; their aim must be still further to reduce it. It must be remembered that our daughter countries can point to a still lower rate—for instance, the mortality rate for the whole Commonwealth of Australia in 1919 was only 69.21 per thousand births for children under one year. The aim of the Baby Week Council is not only to reduce the death-rate, but also to reduce the correspondingly high damage-rate among the children who manage to survive. It has been said that every social problem takes its toll of child lives. Bad housing, defective sanitation, alcoholism, venereal disease, industrial employment of mothers, all these must be held responsible to an enormous extent for the heavy damage-rate among little children in this country.

CONFERENCE ON INFANT MORTALITY

The second English-Speaking Conference on Infant Mortality was held in connection with this National Baby Week in London from July 5th to the 9th. There were twenty-six English speaking countries represented and there were about six hundred people present.

One day was given over to a discussion of residential provisions for mothers and babies. Dr. Janet M. Campbell, Senior Medical Officer of the Ministry of Health, read a paper on Maternity Homes. "Maternity Homes provide from ten to twenty beds for normal and slightly abnormal cases," said Dr. Campbell. "They are needed in large towns to supplement the hospital, but they are also needed in smaller towns and country districts."

As proof of the need of these homes, she said that "in 1900 the maternal mortality rate was 4.8, the total number of maternal deaths due to pregnancy and child bearing being 4,455. At that time the infant mortality rate was 154 per thousand births. In 1920 while the infant mortality rate had fallen to 80, the maternal death rate was 4.2 with 3,942 deaths. Dr. Campbell said further that "in 1919, however, the Registrar-General reported that puerperal mortality was higher than for any year since 1905, and that the increase was preponderently due to sepsis."

In closing Dr. Campbell said: "Properly directed and used, the Maternity Home will undoubtedly serve as one of the most effective weapons in the endeavor to raise the standard of midwifery, and so reduce the disastrous death rate among mothers. Rightly conceived, it forms one link in a chain, related on the one hand with the ante and post-natal clinic, and on the other with a Maternity Hospital (or Medical School) and its consulting staff, in touch with the district midwifery of its own area and available for the local medical practitioner, its value as a treatment center and as an example and incentive to sound midwifery practice can hardly be over-estimated. Thus established and thus related a Maternity Home becomes an institution of the highest national importance, first, for the safe delivery of the child and the proper treatment of the mother, and secondly, for the advance of the science and art of Medicine."

Mrs. Cyril Smithett, of the Young Women's Christian Association, in speaking on "Homes for the Unmarried Mother and her Baby," said: "More and more in these modern times people are realizing that the old Penitentiary organization is out of date, except in a few individual cases, and although it did an immense amount of good work in the past, it does not now meet the needs of the present day girl. But on the other hand, if you send her to a place which is not even called a Home in the Institutional sense of the word, but a hostel, allow her to wear whatever clothes she pleases, force her to keep no regulations but those necessary in any house where girls are gathered together, and in short, treat her as an ordinary human being, then, and only then, will you have some chance, at least, of making her a useful, well-conducted citizen."

Miss Halford presented some Economic and Administrative Aspects of the Problem of Residential Provision for Mothers and Babies. Miss Halford discussed the cost of Municipal Maternity Homes, of Convalescent Homes, of Homes for Babies (for the well and for the sick), showing that it costs far more to keep a baby in a Home, however economically managed, than it does in a home without a capital H. She deplored the fact that the house shortage and consequent overcrowding in the homes is still so prevalent that it seems impossible to hope for any immediate reduction in the number of Homes for Babies.

The other papers read on the first day covered provisions for Blind Babies; for Ailing Infants and Children; for Mothers and

[A full report of this Conference is now being published by the National League for Health Maternity and Child Welfare, 4 Tavistock Square, London.]

Infants Under the Poor Law.

The papers on the second day were on "The Supply of Milk: Its Physiological and Economic Aspects."

The topic for the third day was "Inheritance and Environment as Factors in Racial Health."

Japan

PLANNING A CHILDREN'S BUREAU

A Children's Bureau for the care and protection of the children, is planned by Japan. A list of the best books, pamphlets, and periodicals dealing with the various phases of child welfare work, is asked for, as it is the purpose of the Department to purchase a full reference library on this subject. The editor of the Bulletin of the International Congress asks the various national correspondents of the Congress to furnish book-lists from the publications of their own countries.

Serbia

MINISTRY OF SOCIAL WELFARE

A recent issue of the Bulletin de l'Union Internationale de Secours aux Enfants states that a Children's Bureau is one of the divisions of the Ministry of Social Welfare now operating in Serbia. Among the objects for which it was formed are the following: To assure the proper physical and mental training of the children; to investigate health conditions and child mortality; to secure needed legislation; to obtain an equitable distribution of the government appropriations for child welfare; to supervise government child welfare agencies and cooperate with private agencies of the same sort, giving financial aid when necessary. In March 1920, it was estimated that the number of needy Serbian children was 200,000, half of whom were orphans.

School attendance, which is supposed to be compulsory in Serbia, is almost non-existent because of the destruction of many school houses, and the long distances children must travel to reach school. An appropriation of $10,000, however, is announced by the Junior American Red Cross to be administered in the rebuilding and equipping of the district schoolhouses, and which is a sufficient sum to guarantee the completion of twenty of the forty schools imperatively necessary.

The Serbian government proposes to establish in each province the institutions needed for the dependent, defective, or delinquent children, and also for children who are delicate or ill.

Australia

MATERNITY ALLOWANCES

A bonus of five pounds is paid for every baby born within the Commonwealth, irrespective of the financial status of the parents. During the fiscal year 1919, the number of claims paid was 124,016, which number is only a little less than the number of births for which allowances might have been claimed.—(*Evening Star, Dunedin, New Zealand.*)

Belgium

THE BRUSSELS CONFERENCE

The Second International Conference on the Protection of Childhood was held in Brussels from July 18th to the 21st, 1921. More than 1,200 delegates from all over the world were present.

The Congress considered four main subjects: delinquent and neglected children; abnormal children; health and infant welfare; and the supervision of war orphans.

The first question related to the best means of securing the co-operation between children's courts and voluntary agencies working for child welfare.

Consideration was also given to the problem of the discharged delinquent. The members felt that there is great risk in sending a delinquent boy or girl straight from the seclusion of the reform school or convent to the perfect freedom of the outside world. The official English delegate strongly urged that a child's natural place is the home, and that no pains should be spared to persuade the parents to improve the home surroundings so that the child might return there as soon as possible. A resolution was passed to provide that, if home conditions were such as to make the return of the discharged delinquent unwise, he or she should be boarded with a carefully chosen family, or sent to an intermediate home, which would ease the transitio from the restrictions of the reform school to the freedom of life outside.

There was much discussion on the subject of illegitimate children, Sweden having passed a law three months ago providing that paid guardians should be appointed for every illegitimate child.

The classification, special training and care of abnormal children in both town and country was discussed and the desirability of careful psychological tests as a basis for classification of such children was emphasized.

In regard to health and infant welfare, resolutions were passed to the effect that infant welfare centers should be encouraged, that health visitors should be trained, that midwives should be qualified by examination for their work, and that the number of homes should be increased to which unmarried mothers could go with their babies.

In considering how a country may best express its sense of responsibility for the care of the children of its soldiers killed in the war, it was decided that the nation should be represented in the home of each war orphan by a visitor.

At the close of the conference on July 21st it was announced that the delegates had with one voice determined that there should be in Brussels an International Association for the Protection of Childhood, which will co-operate with the League of Nations to ensure that its work does not overlap that of the League.

Austria

BABY CLOTHES NEEDED "WHEN SAW I THEE NAKED AND CLOTHED THEE NOT."

THREE thousand babies a month are born in Vienna alone, and they remain naked until charity finds garments for them. There is no cloth to be got in Vienna; the textile mills have no coal since Upper Silesia is closed; no cloth can be produced; an ordinary suit of men's clothes costs eighty dollars, and the average salary of the head of a family is two dollars a month.

"In every American home there is a closet shelf, a trunk in the attic, an unused bureau drawer, filled with pieces of cloth that in Vienna would be more precious than rare lace. There are the fine cotton petticoats that one doesn't wear any more, but that somehow haven't been thrown away at house-cleaning time; there are the half-yards of goods left from the spring sewing, the bargain-remnants that somehow have never been made up, pieces of flannel, of lawn, balls of yarn left from making sweaters—a whole treasure-trove unused and useless and quite disregarded—so rich are the American women.

"The closets of Viennese women are bare, the rag-bags have long been emptied, the bags themselves have made underwear long since worn out for children; there are no sheets on the beds, for the sheets have been made into garments.

"These Viennese mothers are not the "poor classes" of Vienna. They are the wives of doctors, lawyers, professional, and business men. Before the war they would have made dozens of little garments, tucked and hemstitched, for their babies, and laid away in perfumed bureau drawers to wait for the baby's birth. Now they have nothing. Their husbands work, and earn—in a city where prices are nearly as high as in America—perhaps a dollar and a half, perhaps two dollars and a half, a month. And the city of Vienna issues to the women a 'Charity passport.'

"Seventy-five per cent of the Viennese women carry this piece of paper that says they have not enough to eat, nothing but rags to wear, and no money, and that therefore, for their children's sake, they can have no pride. This piece of paper, stamped by the Friends, by the American Relief Administration, by the American Red Cross, takes them from organization to organization, getting here a little food, there a little medicine, in another place a little clothing. It is the 'Charity passport' that will get them something to put on the baby when it is born.

"If American women understood what Viennese mothers are suffering they would send help; they would, every one of them, spend a few hours a week making again those soft, beautiful, unspeakably precious baby-things that bring tears from the Viennese woman who sees and touches them."—*The Red Cross Bulletin,* July 11, 1921.

Recent Literature on Mother and Child Welfare

Reviews

Health Plays for Children. [As developed by Teacher and Pupils in the Public Schools of Greater New York.] Printed by the Health Service of the New York County Chapter, American Red Cross, for the Child Health Organization of America, 370 7th Avenue, New York City.

This is a group of impromptu health plays with gay illustrations and suggestions for costumes and properties. The work of teachers and pupils in New York Schools, it is filling the need of the schoolroom for simple material to interest children in acquiring health habits. Some of the playlets are in verse, some in prose. Most of them are short and adaptable to any of several grades and ages. A few are longer and more elaborate.

The names of the plays give an indication of the variety of material: *The King of Foods**; *The Wizardry of Milk; The House That Health Built**: *The Pied Piper of Health*: *The Value of Milk*: *The King of Foods*: *The Carpenters' Union*: *Our Friend Milk*: *The Road To Health*: *Young American and The Magic Carpenters*: *A Day in Happy Land*: *The Magic Milk Game*: *Mary's Vegetable Garden*: *The Story The Milk Told Me*: *Dr. Milk Bottle**

Many boys and girls will be eager to impersonate the essentials of child health. Teachers and health workers who have been looking for just such assistance will be glad to know that the first edition is being distributed without charge by the Child Health Organization of America. A new edition will be made available at cost if the demand warrants it.

"MY HEALTH BOOK"

This leaflet, prepared by the Child Health Organization of America, is intended to capture the interest of adolescent girls. It is the greatly simplified result of a plan originally tried out with the Girls' Friendly Society of the Episcopal Church and with groups of Girl Scouts.

The psychology of the growing girl has been carefully considered and helpful suggestions that are sound and practical are presented in a form which is both dainty and compact. The idea of beauty through health is stressed, and a real solution suggested for some of the chief health problems of girlhood. "Every girl wants to make a winning game of her life", so runs the legend beneath the gay cover illustration. "My Health Book" suggests that this victory is attainable when health is secured.

*The plays which are starred were referred to in the issue of Mother and Child for October, 1920.

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The College and the Essential Needs of Humanity

President Angell, in concluding his inaugural address, said: "As the dark mists of the great war roll slowly away, America is standing upon the threshold of a new day. To us as a people it brings unparalleled opportunities, deep and compelling obligations. For all humanity, it is of paramount consequence in what manner we meet this crisis. If we are guided by the divine that is in us, we may yet transfuse into permanent forces of beneficence those superb impulses of self-sacrifice and loyalty which characterized our national attitude in the war. On no one of our institutions does this burden of national responsibility fall more heavily than on the colleges and universities. Theirs it is to set a new standard of excellence, a new ideal of service to mankind, a new conception of the devotion of trained intelligence to the essential needs of humanity."

MOTHER AND CHILD

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NEW HAVEN'S HEALTH PLANT

What of the city and those who live there? New Haven, settled in 1637 by a colony of English Puritans, is today made up of a cosmopolitan group, in fairly well-balanced proportions. It is true that the name New Haven brings to the minds of most of us the idea of a University center, but this college town has grown to be a very large manufacturing city. The largest proportion of its population are factory employees, the majority skilled workmen, and the balance the new foreigners, mostly Italians, Slavs and Russian Jews, with a considerable number of second-generation Irish. Each nationality lives in a special locality so that now New Haven has an Italian, a Polish, and a Jewish district. There are also about 8,000 negroes, mostly living within a small area.

Among the industries of the city are factories making fire arms, the clock shops, and a great variety of machine shops, all employing high grade labor. The rubber and clothing factories fall into a group by themselves. The large railroad carshops and home offices greatly influence the industrial life of the city.

The Nurses' Work for Children

Miss Elizabeth Ross, the Associate Superintendent of the New Haven Visiting Nurse Association, when asked to furnish an account of the contribution made by the nurses to the health work of New Haven, gave the following account:

"In discussing New Haven's Health Plant, it will be necessary to consider all the types of population, and their work. A certain proportion of the residents in this University City have almost no connection with the nurses doing field work. About one-fifth of the children are educated in private

schools, leaving about 133,000 to receive some type of nursing service.

"Public health nursing and bedside care in New Haven is distributed among several organizations, the largest being the Visiting Nurse Association. This has a corps of fifty-six nurses, one trained home economics worker, four untrained helpers, and an office force of seven.

"The Board of Health of New Haven has a nursing force of twenty nurses, ten of whom are assigned to school work, and the balance to welfare and contagious disease work.

"The Crippled Children's Aid Society has one nurse. The New Haven Dispensary has three nurses who go out into the field. The Municipal Venereal Clinic has one field nurse.

"All told, our nursing force for the city amounts to eighty nurses. This is exclusive of all other field workers. This number of nurses to a population of 163,000 virtually means a nurse to every 2,000 people, the figure that was considered by the Cleveland Survey as the maximum number to which a nurse can give adequate care. Compared with most other cities, New Haven should be able to make an ideal demonstration of Public Health Nursing.

CARE BEFORE AND AT BIRTH

"The prenatal work, carried on under the auspices of various nursing organizations, is comparatively small compared with the births of the city. The Visiting Nurse Association has an obstetrical department which is less than a year old. In nine months they have had under their supervision 339 prenatal cases. Of these cases the nurses of this department have attended the delivery of 138. The nurses in the Health Center also do systematic prenatal work, referring their cases to the prenatal clinic of the Health Center. The New Haven Dispensary does obstetrical work in the homes, two nurses being assigned to this service from the dispensary. Last year they took care of about 300 cases. In addition to this systematic prenatal work, a considerable amount of effort along this line is expended by all of the nurses who do any child welfare work.

"The number of births in New Haven for the year 1920 was 4,375. Of these births, 1,198 took place in the hospitals; approximately 1,400 were delivered by midwives. This leaves, in round numbers, about 1,800 births to the general practitioner in the homes. The Visiting Nurse Association gave post-partum care to 469. We have no way of knowing what kind of care was given in the balance of the cases, but it is easy to assume that a certain proportion, probably not over 10% was cared for by graduate nurses, in the homes. We may say that our actual knowledge covers two-thirds of the births.

"The infant mortality of the city of New Haven stands at 86.67 per thousand. Besides this, we have a record of still births for a year of 133. These figures, if taken together, would give us about 500 infant deaths for the year, making in round numbers 3,700 living children under one year in our city. This group of infants comes under the care of the Child Welfare Department of the Visiting Nurse Association of New Haven. The birth certificate is delivered by the Board of Health.

"The Child Welfare Department of the Visiting Nurse Association of New Haven has under its care children up to five years of age, of whom there are 21,000. Twelve nurses are assigned to the Child Welfare Department, which maintains fifteen Well Baby Conferences, and two pre-school conferences. These conferences are held in a great variety of places; four in school buildings, three in settlement houses, two at the hospitals, two in church vestries, one in a branch library, one in the "Keep Well House" of the Health Center, and one in the Seamen's Bethel. Conferences are held weekly, and are conducted by the nurse in the district where the conference is held, and supervised by the head of the Child Welfare Department. There is a doctor in attendance in each conference. No medication of any kind is given, only feeding

In this Vestry Room well babies and children of pre-school age are brought for physical examination and supervision.

cases are prescribed for. All other cases are referred to the two children's clinics of the hospital or to private doctors. (In the Health Center where the generalized nursing is done, the Child Welfare work is a part of the general program.)

"The Child Welfare Department has under care about 4,224 children. A large proportion of these are infants, but considerable work is being done for the pre-school child, and a special program for the under-nourished pre-school children is being carried on in connection with the Child Welfare Conferences. These are under the joint supervision of the Home Economics and Child Welfare departments. Special doctors take charge of these nutritional clinics, and the nurses and Home Economics workers do follow-up work in the homes. The Board of Health does a certain amount of work with this group, especially in the control of contagious diseases. There is also one other organization that must be considered, that is, the Crippled Children's Aid, which has the superversion and care of orthopedic cases.

"The supervision of the babies in the Day Nurseries and Kindergartens in New Haven comes under the Child Welfare Department of the Visiting Nurse Association. The Dispensaries maintain clinics for sick children and the two hospitals have children's wards.

"During the summer a Baby Hospital was maintained at the Seamen's Bethel. This was at one time an active organization caring for the sailors who came to New Haven, but as the city is no

Sick Babies Snug Harbor, a summer hospital formerly the chapel in the Seamen's Bethel

longer a shipping port, the money for this work accumulated. It was necessary to secure legislative action by the state in order to make use of certain funds. The Babies' Snug Harbor is the result. This

"All the health work for the 35,000 school children is carried on by the Board of Health, which assigns ten nurses, under one supervisor, to school work. The Board of Health plans to give each child, during

These babies come to the library, not for books, but to see the doctor and nurse in the well baby clinic which is held in the library basement. At the left is the special school for abnormal children directed by Professor Gessell.

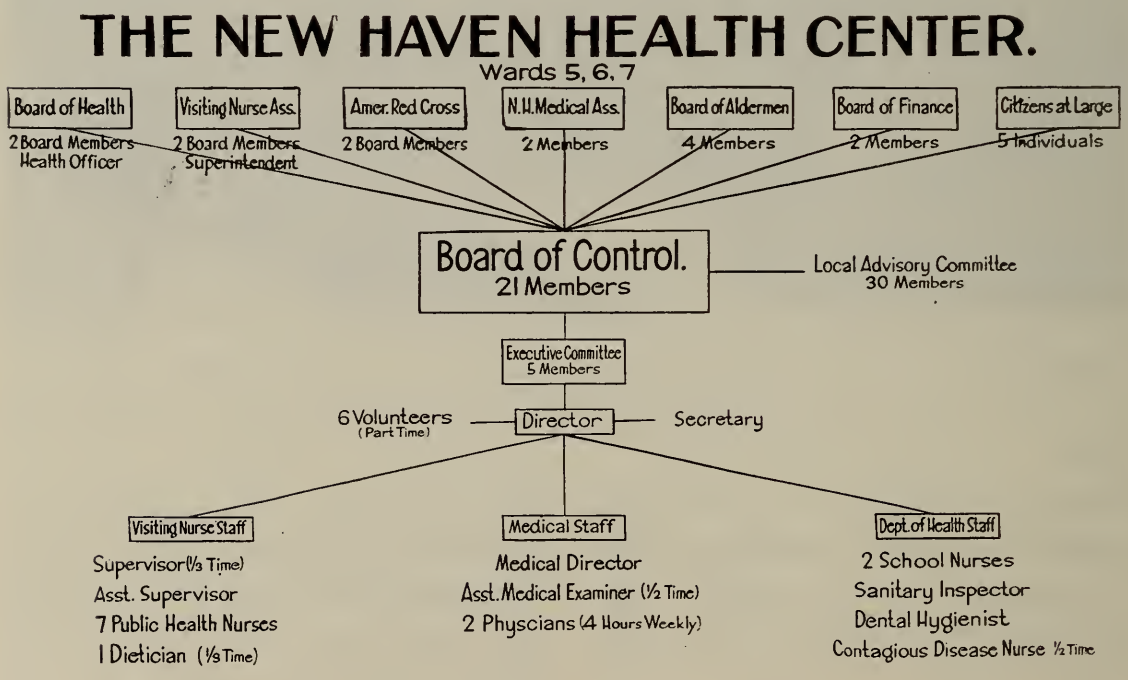
hospital was carried on in close connection with the Visiting Nurse Association an dthe Health Center, the hospital being in the Health Center district.

the school life, three physical examinations, one on entering school, one during the third year, and the last about the sixth year. The school department carries on nine

nutritional clinics for under-nourished children. There are Health Leagues conducted by the children under the supervision of the teacher. These Health Leagues carry out a daily program. Twelve Little Mother Leagues are conducted by the school nurses. The city maintains seven special schools and two open-air rooms. Children's teeth are examined and two full-time dentists and two dental hygienists are part of the working personnel. The Board of Health conducts vaccination clinics in the schools. The school nurses do follow up work in the homes, referring the clinical cases to the private doctors, the dispensary, or to the Visiting Nurse Association.

In concluding her description of the Visiting Nurse Association Miss Ross says:

"In discussing the health-program for the group in industry we can only say that there is no plan that in any special way protects the health of this group. While a number of industries have welfare departments, and maintain first aid rooms and industrial nurses, what health work is done is usually the care of the person who is diagnosed as physically unfit or those who, in case of industrial accident, come under the compensation laws. A somewhat more complete program is carried out in regard to Tuberculosis, as the Employees' Tuberculosis Relief Association has a large industrial membership and gives considerable financial aid, while the nursing work is done by the Tuberculosis Department of the Visiting Nurse Association."



In the Keep Well House

The Health Center *

The New Haven Health Center was opened July 12, 1920 under the auspices of the Board of Health of the city, the Visiting Nurse Association, the New Haven County Chapter of the American Red Cross, and the New Haven Medical Association. These health agencies are working together to offer the best possible service to a definite district consisting of three wards, covering approximately 360 acres of ground.

The Health Center carries on active health education work by means of a health Education Service, posters, motion pictures, slides, and circulars on health subjects, as a special need creates the demand. The medical staff gives medical examinations and hygienic advice, referring people who need medical care to their own doctors, or to dispensaries, or to hospitals. The Center not only tries to prevent sickness but it sees to it that sick people have proper nursing and medical care. In the Health Center area, there are seven nursing districts, each having one nurse doing generalized nursing, under the supervision of Miss Elizabeth Ross. The nurses' work includes teaching families how to keep well.

*For a full account of this subject see "A Health Center with Emphasis on Health," by Philip S. Platt, C. P. H., Director, New Haven Health Center, in The Nation's Health, September, 1921, page 490.

As representative of the Health Department, the Health Center has the control of communicable diseases, re-admittance to school of school children, and the responsibility for the sanitary conditions of the district in which there are about five thousand families, or 27,000 people, 40 per cent of whom are foreign born, 48 per cent, native born of foreign parentage, largely Italian. Four Infant Conferences are held in the district, and nutritional classes under a part-time dietitian from the Visiting Nurse Association.

The building occupied by the Health Center is called The Keep-Well House. It is on a thoroughfare in a busy part of the Italian section of the city. There is one large reception room, two small examination rooms, a laboratory, office room, and a large room for meetings.

Excellent cooperation exists between the center and all the health and social welfare agencies of the city, including the settlement, boys' clubs, day nurseries, kindergartens, playgrounds, the churches, the Salvation Army, the Y. W. C. A., and the Seamen's Bethel and Snug Harbor Babies' Hospital.

There is a Local Advisory Council of thirty representative citizens in the district. This Council meets upon the call of the director of the Health Center, Mr. Philip Platt, to discuss local questions and give its advice and support.

The University's Concern With Health

In writing of the health activities of the University, Professor Lafayette B. Mendel speaks of "the Department of Pediatrics (in connection with the school of medicine and the New Haven Hospital), under the charge of Dr. Edwards A. Park; the work in school hygiene (in connection with the Department of Education) for which Professor Arnold L. Gesell is responsible; the Laboratory of Applied Physiology in which Professor Yandell Henderson and his associates are engaged in studies on respiration in relation to ventilation and associated problems; the Department of Public Health and Preventive Medicine under the direction of Professor Winslow; the Laboratory of Bacteriology under the direction of Professor Rettger, whose recent studies of the transformation of intestinal flora have aroused widespread attention."

Professor Mendel further says: "The Department of Physiological Chemistry is conducted in the Sheffield Laboratory of Physiological Chemistry, 2 Hillhouse Avenue, where investigations are in progress in relation to the distribution of vitamines in natural foods, the digestion and utilization of a variety of food products including a study of the comparative utilization of different types of carbohydrates that are employed in infant feeding, studies in metabolism, and so forth.

"The work in which Dr. Osborne and I have been jointly engaged for more than ten years, under the auspices of the Carnegie Institution of Washington, is conducted in the research laboratories of the Connecticut Agricultural Experiment Station in New Haven. They have involved, broadly speaking, problems of protein chemistry, the relative value of different proteins in nutrition, the role of inorganic salts, the nature and distribution of the different types of vitamines, diseased conditions arising from deficiencies of diet, and so forth. At the present time, we are engaged in extensive studies of the effect of unusual combinations of food factors upon growth."

The Department of University Health in Yale

The administrative functions of this Department are in the hands of the Director, Dr. Greenway, acting under the authority of the University Board of Health. The staff includes medical assistants, a sanitary inspector and laboratory assistant, a surgeon, and an orthopedist part-time man to care for conditions of the eye, ear, nose and throat. Several other part-time men assist in routine examinations.

A VIEW OF THE CAMPUS FROM DWIGHT HALL

Should the medical or orthopedic examination divulge any condition which is susceptible to correction, the student has this carefully explained to him and if the condition is such as to make advisable, it provides an opportunity

to give him hygienic advice at a time when he is particularly impressionable. In the case of freshmen, should there be an orthopedic defect such as curvature of the spine, flat feet, postural defect, and so forth, the student is required by Faculty Ruling to carry out prescribed corrective exercises in special classes arranged at the Gymnasium during the period between the Thanksgiving and Easter recess.

Any member of the University has the privilege of consulting the Medical Staff of the Department on any matter relating to his physical welfare, such as hygienic advice, medical examination, or vaccination against smallpox and typhoid fever.

EXAMINATION OF ENTERING STUDENTS

It is now required that all undergraduate students be examined as soon as possible after the beginning of the college year. All men engaging in competitive athletics, competitors for the Daily News, and food-handlers in the University Dining Hall are required to undergo a careful medical and physical examination before beginning their work. In addition to these required examinations any member of the University has the privilege of examination by the Department.

This examination is a thorough one including chemical and microscopic examination of the urine, blood pressure determination, and pulse observations, before and after exercises, and so forth.

SUPERVISION OF THE HEALTH OF ATHLETES AND OTHER SPECIAL GROUPS

A phase of the work of particular importance is the supervision of the health of students engaged in competitive athletics. Such supervision is intended to be not merely remedial but preventive and involves fundamental study of the effect of various forms of athletic exercises upon health in order that real danger may be avoided while sweeping criticisms of competitive athletics may be submitted to the test of scientific study.

SANITARY SUPERVISION

In order to insure the proper sanitary environment a sanitary inspector has been engaged who has general oversight of the College Buildings, Dormitories, and University Dining Hall. There is a regular bacteriologic examination of the water, milk, and ice cream consumed.

This Department provides a central authority for dealing with the isolation and quarantine of cases of communicable disease which may arise in the student body, and makes possible the proper investigation of any such outbreaks as may occur.

American Child Hygiene Association

Twelfth Annual Meeting

New Haven, November 2-5, 1921

MEETING PLACES

The general headquarters will be at the Hotel Taft. Accommodations for the meetings and exhibits have been provided at Sprague Memorial and Lampson Halls, Yale University; the New Haven Hospital and the Hotel Taft.

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Wednesday, November 2

10 A. M. Annual Meeting of the Executive Committee
Mezzanine Floor of Hotel Taft

11 A. M. Annual Meeting of the Board of Directors
Mezzanine Floor of Hotel Taft

2 P. M. GENERAL SESSION
Sprague Memorial Hall

COORDINATION OF CHILD HEALTH ACTIVITIES

Courtenay Dinwiddie, Washington, D. C., presiding

1. Local Coordination
Haven Emerson, M. D., New York City

Discussion:

S. Josephine Baker, M. D., New York
Ella Phillips Crandall, R. N., New York

2. State Coordination
Walter Brown, M. D., Mansfield, Ohio

Discussion:

3. National Coordination
Charles E. Sawyer, M. D.,
Brigadier General U. S. M. R. C.
Washington, D. C.

Discussion:

Philip Van Ingen, M. D., New York City

4 P. M. Visit to Health Center
574-578 Grand Avenue, New Haven

8.30 P. M. Annual Business Meeting of Association (Members only)
President H. L. K. Shaw, M. D., Albany, Presiding
Sprague Memorial Hall

Thursday, November 3

10 A. M. GENERAL SESSION
Sprague Memorial Hall

President H. L. K. Shaw, M. D., presiding

1. President's Address

2. General Director's Report
Progress in Child Hygiene Work in this Country

Discussion:

Anna E. Rude, M. D., Washington, D. C.
Julius Levy, M. D., Newark

3. Roll Call of Affiliated Societies

2 P. M. GENERAL SESSION
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HEALTH EDUCATION

Thomas E. Finnegan, Ph. D., Harrisburg, presiding

1. The Home and Child Hygiene
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Sprague Memorial Hall

HEALTH EDUCATION

Thomas E. Finnegan, Ph. D., Harrisburg, presiding

1. The Home and Child Hygiene
Mrs. Charles H. Remington, Providence, R. I.

Discussion:

2 The Establishment of Health Habits in the Kindergarten

Miss Julia Wade Abbott, Washington, D. C.

Discussion:

3. The Psychology of Health Education

Mrs. Arnold Gesell, New Haven

Discussion:

12.30 P. M. Luncheon for Nurses

Place to be announced later.

4 P. M. ROUND TABLE

Sprague Memorial Hall

RURAL PROBLEMS

Frances Sage Bradley, M. D., Washington, D. C., presiding

1. Rural Obstetrics

F. L. Adair, M. D., Minneapolis.

2. Nutrition of the Rural Child

A. Period of Infancy

Ethel M. Watters, M. D., San Francisco

B. Period of School Life

Mrs. Ira Couch Wood, Chicago

3. Habits of the Rural Child

E. C. Branson, Chapel Hill, N. C.

4. County Centers

W. S. Rankin, M. D., and Rose M. Ehrenfeld, R. N., Raleigh, N. C.

Discussion:

E. J. Huenekens, M. D., Minneapolis

8.30 P. M. PUBLIC MEETING

Sprague Memorial Hall

President H. L. K. Shaw, M. D., presiding

Friday, November 4

10 A. M. GENERAL SESSION

Sprague Memorial Hall

PROBLEMS AND OPPORTUNITIES OF LAY DIRECTORS OF PRIVATE ORGANIZATIONS

George R. Bedinger, New York City, presiding

1. The Value of Lay Cooperation in Health Work

Roger I. Lee, M. D., Cambridge, Mass.

2. Administrative Problems of Lay Directors of Private Organizations

Homer Folks, New York City

3. Financial and Publicity Problems of Lay Directors of Private Organizations

John S. Ellsworth, New York City

Discussion:

J. Prentice Murphy, Philadelphia

Borden S. Veeder, M. D., St. Louis

10 A. M. ROUND TABLE CONFERENCE OF DIRECTORS OF DIVISIONS OF CHILD HYGIENE

Room 2, Lampson Hall

Ellen C. Potter, M. D., Harrisburg, presiding

1. The Organization of State Divisions of Child Hygiene with Especial Reference to Emphasis Placed by the Budget

Merrill E. Champion, M. D., Boston

2 Relation of the Official (State, Municipal) Child Welfare Activities to Private Physicians

E. V. Brumbaugh, M. D., Milwaukee

3. Public Health Nursing in Relation to the Work of Child Hygiene Divisions

Margaret K. Stack, R. N., Hartford

4. Is a State or Municipal Official Prenatal Program Practicable, and if So, What Is Its Scope and Method?

S. Josephine Baker, M. D., New York

Ethel M. Watters, M. D., San Francisco

2 P. M. GENERAL SESSION

Sprague Memorial Hall

THE CHILD OF PRESCHOOL AGE

William Palmer Lucas, M. D., San Francisco, presiding

1 Psychology of the Preschool Child

C. Macfie Campbell, M. D., Boston

Discussion:

2. Day Nurseries

Mrs. Laurence Hamill, Cleveland

Discussion:

Mrs. Edward Bushnell, Cleveland

3. Recreation

Mary Margaret Roche, R. N., Grand Rapids

Discussion:

8.30 P. M. Meeting of the Board of Directors

President H. L. K. Shaw, M. D., presiding

Mezzanine Floor of Hotel Taft

Saturday, November 5

10 A. M. MEDICAL SESSION

New Haven Hospital

Edwards A. Park, M. D., New Haven, presiding

1. The Relation of Obstetrics to the Community

F. L. Adair, M. D., Minneapolis

Discussion:

J. Whitridge Williams, M. D., Baltimore
Borden S. Veeder, M. D., St. Louis

2. Is there any Evidence to Suggest that Poor Posture Bears Any Causal Relation to Poor Health in Children?

Robert B. Osgood, M. D., Boston

Discussion:

3. The Experimental Production of Rickets

Edwards A. Park, M. D.

Discussion:

Lafayette B. Mendel, M. D.

Followed by clinics under the direction of Dr. Park

10 A. M. SESSION ON NURSING AND SOCIAL WORK

(Joint session with Child Welfare Section of the N. O. P. H. N.)

Sprague Memorial Hall

Sara B. Place, R. N., Chicago, Chairman
Anne A. Stevens, R. N., New York City, Vice Chairman

1. Volunteer Workers in a Public Health Program with the Child of Preschool Age

Isabelle Boyce, R. N., Grand Rapids

Discussion:

Olivia L. Carpenter, R. N., Minneapolis
Elmira W. Bears, R. N., Louisville
Esther Beith, R. N., Toronto

11 A. M. Round Table on Records

Sprague Memorial Hall

Anne A. Stevens, R. N., New York City, Chairman

Report of Record Committee of Child Welfare Section of N. O. P. H. N.

Helen Boyd, R. N., Bridgeport

12 M. Meeting of Executive Committee

Mezzanine Floor, Hotel Taft

2 P. M. SESSION ON NURSING AND SOCIAL WORK

(Joint session with Child Welfare Section of the N. O. P. H. N.)

Sprague Memorial Hall

Sara B. Place, R. N., Chicago, Chairman
Anne A. Stevens, R. N., New York City Vice Chairman

1. Teaching Methods and Equipment in Health Programs for the Child Under Six Years

Anne Sutherland, R. N., New York City

Discussion:

Winifred Rand, R. N., Boston
Charles D. Easton, M. D., Washington

4 P. M. GENERAL SESSION

Sprague Memorial Hall

Report of Committee on Resolutions

Announcements

CONDUCT OF SESSIONS

All sessions will begin promptly at the hour announced.

Papers are limited to fifteen minutes. Discussion is limited to five minutes.

A session shall not exceed two hours in length unless so voted by those present at the session.

Each person preparing a paper should send an abstract to the office of the association to be printed in the program sent out in advance of the meeting.

Persons who are not sure of being able to attend the meeting should not accept a place on the program.

Papers of persons not present at the session shall not be read until after the other papers have been read and discussed, and then only provided there is sufficient time before the expiration of the time limit of the session.

All papers presented are the property of the Association and should be handed to the secretary at the close of the session in which they are presented. They may be published elsewhere than in the Transactions of the Association only by consent of the Association.

A Health Center in a City Hospital

Katherine Dillon Ermold, R. N.

Nurse-in-Charge, Social Service Department, City Hospital, N. Y.

A CHILD Health Centre, which forms a new branch of the Department of Public Welfare of the City of New York, and which is under the supervision of Dr. Walter Lester Carr, was organized and developed in the City Hospital on Welfare—formerly Blackwell's—Island, in the fall of 1920. It is the first of its kind to be opened in a hospital in New York City, although there have previously been similar health centre clinics developed and maintained at various dispensaries, public schools, parish and settlement houses throughout the city.

The City Hospital accommodates about 200 children, many of whom are admitted for acute illnesses, and some of whom are permitted to remain for weeks or even months as convalescent patients. Unfortunately, when some of the children are admitted they are scattered throughout the adult wards, owing to the nature of their diseases, such as those affecting the eyes, skin or nervous system, and consequently they at first have adult fare, but through the cooperation of the nurses and the child's own efforts, changes in diet in the way of food substitution, such as milk for coffee and so forth, are effected. A large percentage of these children are not bed cases, but are afflicted with disorders associated with malnutrition, and it soon became apparent that, with their help and assistance, much preventive work could be accomplished, both in the hospital, and later when they returned home, thus supplementing the hospital care. In the feeding cases and where the children are suffering from acute illnesses, dietaries are arranged under the personal supervision of Dr. Carr.

The Health Centre Clinic has been open two mornings each week during the past winter, and about

125 children have been in attendance at various times, or an average of 15 to 20 children each morning since it was opened. When a child is admitted his physical defects, such as tonsils and adenoids, defective eyesight, etc., are noted and corrected as far as possible. The child is impressed with the importance of clean teeth by means of tooth brush drills, and he is gradually taught the proper foods and the rudiments of healthy living. A dental clinic is maintained where the children's teeth are examined regularly and given the best care and attention possible. A chart is always kept of each child, and a careful record is made of his weight, the regularity of the use of the tooth brush and the adherence to the prescribed rules of diet and health. The interest that the children take in their own progress is noteworthy, and likewise their disappointment if they fail to make an expected gain.

These health centres have a twofold value: first, in teaching the child, while under their care and supervision, how to live and eat correctly; and secondly, in carrying this instruction back into the home and to other members of the family.

Here is a typical case of progress made by a boy while a patient in the hospital and a regular attendant at the Health Centre:

William Jones, an intelligent boy of 14, admitted to the hospital during the month of November, 1920, suffering from a tuberculous ankle. He had been a patient at other hospitals, but had made no progress. He was nervous, hard to control and unruly. He would not eat or take proper care of himself. After regularly attending the Health Centre Clinic he became interested in his gradual improvement, and finally, with the benefit of a two weeks' stay in the Burke Foundation (a convalescent home at White Plains, New York), he has been pronounced cured. During all this time he has gained 20 pounds in weight, and has become tractable, courteous and polite. He is a most enthusiastic participant in the health games, takes good care of his teeth and an interest in his diet. He has been placed with a family living in the Bronx for the summer. He attended school just before its close, and made such splendid progress that a scholarship was procured for him for a four-year high school course. The family with whom he is staying is very fond of him.

There are many similar children who have improved in health and have been shown more normal ways of living through the aid of the health lessons that have been taught in the Health Clinic by means of simple games and instruction.

Great credit must be given to the Junior League of New York City, an organization of young women who not merely give financial aid, but come to the Health Clinic two days a week and assist in the instruction of the children. Each young woman is given a group of eight children and each child receives individual attention.

The follow-up work is done by the nurses on the staff of the social service office. They endeavor to keep track so far as possible, of the progress of each child after leaving the hospital.

Fixing Responsibility

Helen MacMurchy, M. D.

Chief of the Division of Child Welfare—Canadian Ministry of Health

Charity is not the only thing that begins at home. Criticism begins at home, too. Alienists say that when we lose the power of self-criticism we are in a bad way. So let us keep that power in practice by a reasonable use of it.

About this question of Infant Mortality. Once upon a time you were on the "Hospital House Staff"—weren't you, Doctor? Do you remember how the other "boys" used to talk about any "House Doctor" who, when his turn came to take the "Maternity Ward" and the "Case", lost one of his patients, the Baby?

It did not take many words. Sometimes no words at all. Sometimes—"Well, of course, I wouldn't want to stand by and see the baby die." In a busy hospital, I wonder what the sum total would be of the hours put in doing artificial respiration for the babies who did not just know how to breathe, and so had to be taught, quietly, carefully, gently, regularly, by the hour if necessary. And then how you felt when the little one "took on the job". There was a tiny gasp, a wee sigh, a gentle heave, a few more turns from you, and he got to work and breathed eighteen times per minute; and there was the baby, pulled up out of the "river over which there is no bridge", and safe on dry land.

No, there are not very many babies that do not know how to breathe. But you do see one every now and then, and *you,* Doctor, *you* have to do the teaching.

You are responsible and you never said you weren't, and you always do it.

There is something else for which you are responsible—just as necessary. The baby knows how to do it almost as often as he knows how to breathe. Oxygen is his first food. Air is his first need. But his second is to be able to nurse and so nourish himself from his mother's breast.

If one hundred per cent of all our babies were nursed at the mother's breast, our infant mortality would compare favorably with that of New Zealand, which is the lowest in the world and about twice as low as in any other country.

Doctor, what are you going to do about it? Leave it to the nurse? No! You are responsible. The nurse will help you—she often does, with artificial respiration. But *you* are the one responsible and *you* must see it done.

There is no other way.

The Shortage of Nurses

S. Lillian Clayton, R. N.
Superintendent of Nurses, Philadelphia General Hospital

THE shortage of nurses is the symptom of a serious condition. The causes of this condition are of long standing, and its results are as far reaching as its evil effects. Not only are the causes of long standing, but they have been unnoticed by most of us. A few who have been interested in the tides of human endeavor, or active in the fields of science, education, labor or politics, have heeded and have sounded repeated warnings. But the results as a whole have not been considered. Only in their relation to individual, personal, institutional, or community needs, have they been appreciated. Today it would be impossible to over-estimate the seriousness of the situation in nursing, or to over-emphasize the importance of the broadest and most co-operative attitude on the part of every one toward this problem.

SOME RESULTS OF THE CONDITION

Public health agencies throughout our land, and those which are endeavoring to help the peoples of other countries, are demanding and must obtain better material for the great task of health education if their efforts are to be successful. More and more urgently come appeals from communities everywhere for nurses who, through the sound education which they have received in the care of the child before birth, and during infancy, pre-school and school age, are prepared to help safeguard for the country its citizens of tomorrow. In far too many instances these calls remain unanswered, not only because there are insufficient numbers of nurses, but because their education in the training schools has not prepared them to meet these demands that are of such great import to the public. Moreover, the hospitals are unable to staff their wards, to extend their research work, or to enlarge their usefulness in the communities they would serve. Nor can the practitioner be assured that his patients in their homes are always receiving intelligent and conscientious care.

WHAT ARE THE REASONS?

Today, when we find all advanced educational institutions are receiving more would-be matriculums than they can accommodate, when we find our nineteen university schools of nursing with full enrollments, and when we know that classes are complete in others of our finest nursing schools—with the exception of a few which are meeting modern demands, but which are at the same time living down memories of past low standards—why do we not find sufficient numbers

of students in the rank and file of schools of nursing all over the country? We may find our answer to these questions in the following statements:

1. The present system of nursing education, because of the economic demands of the hospital, prevents the proper presentation of the educational material, and limits the amount of time for the study of the educational problems either theoretical or practical. All of this is the direct result of holding on to much of the traditional method of nursing education while introducing new methods in our effort to meet in every way both the present day demands of the public and of the medical profession.

2. The burden of this adjustment rests upon the supervisors and teachers of the schools; and because of the weight of this burden we find frequent changes in the personnel, thus adding another factor to the inadequate preparation of the nurse. What have we in mind when we speak of "sufficient" number? Usually the number necessary to care for the patients in the hospital of which the school is a part. But should the care of these patients be dependent wholly upon a student body? Should there not be a nursing staff giving its sole and undivided attention to the care of patients, this staff to be supplemented by the students, whose interests must necessarily be divided between the patient and the education they, the nurses, are hoping to receive? This is borne out by answers which have been received from promising high and normal school graduates in reply to requests for their reasons for refusing to consider nursing as a profession. They say, "Perhaps the opportunities in nursing are good; but are they worth all the hard work and the long hours of the average hospital course, and after the completion of the course, are the graduates prepared to meet the demands made upon them by the public?" Not only do the young women themselves have these opinions about schools of nursing, but those to whom they naturally turn for advice in choosing a career—high school principals, teachers, parents—share this attitude with them.

We must admit that there is, at present, much prejudice against our schools of nursing, some of which is well founded, and some unfounded, and no amount of clever and appealing publicity will change public opinion permanently if the conditions as they actually exist in schools do not measure up to the pictures painted of them.

SERVICE VERSUS DRUDGERY

Without doubt, nursing is today one of the strongest forces at work in our midst, and one that truly can be considered a great public good. In order to appreciate this fact clearly, and to understand the ground for such assertions, one

must inquire into the aims and purposes of nursing.

The young woman of today desires to find an outlet for her energy. She really wants to be of service. But she wants to be educated for service. She is unwilling to be a machine. She desires to study her problems, but she must have time for such study. She wants to work, but she desires to play also. She wants to nurse her patients, but she desires also to have time for normal reactions as does her sister in any other profession. She is willing to accept discipline for the community good; but the discipline must be reasonable, such that she can understand, —not the type which must be accepted unquestioningly and which has been handed down from the military systems existing in hospitals a century ago.

She wants to belong to a profession which means that the patient is considered first; but she is not willing to enter upon a course of training or into a profession which requires that its education and its service be entirely subservient to the needs of the hospital and the patients therein. The evolution of the nursing profession has been interesting. Until recently it was not recognized that opportunities for theoretical as well as for practical education are necessary; not merely because the young woman demands something different, but because the public and the medical profession are requiring the type of service that must have for its preparation both phases of education.

THE TRUSTEES' OBLIGATION

The hospitals continue to conduct their schools of nursing on the apprenticeship basis. Many are willing to do otherwise, but with large deficits already facing them, their trustees hesitate to assume what seems to them further impossible financial burdens. The trustees believe, and rightly so, that the funds which have been entrusted to them by their contributors, are primarily intended to be expended for the care of the sick. But with the establishment within the hospital of a school of nursing the trustees of that hospital have assumed an obligation toward a second group of people, namely the student nurses; and this obligation so far as the students are concerned is one of education. Every hour these students spend within the hospital walls should be of educational value to them. To bring this about requires that they be of little economic value to the hospital, and the hospital contributors should clearly understand that the introduction of a school of nursing into the hospital which they are supporting, means a dual obligation and not a solution of one of the hospital problems.

THE REMEDY

There must be a realization on the part of the public that at least some of the burden of the education of this public servant—the

nurse—should rest upon the community and upon the state, and not as heretofore entirely upon the hospitals. The nursing profession shares with the medical profession the responsibility for the physical health of the next generation, just as upon the teaching profession rests the responsibility for the mental health of that generation. For the public to realize this fact, requires that they be informed by boards of trustees of hospitals in which schools of nursing have been established that there exists within these hospitals the need for support for two activities: First, the care of sick within the hospital walls; second, the education of a group of women to care for the patients in that hospital, in that and other communities, and under all circumstances; and to have them educated in the principles of disease prevention as well as of disease alleviation.

May we not have a realization on the part of hospital trustees, that slowly but surely must come the substitution of the educational for the apprenticeship system in the preparation of the nurse? That when proper educational standards are maintained in schools of nursing, the student will pay in part for her education, and the tuition fees will help to provide the necessary teaching equipment and the salaries for the instructors; that she will also pay for her maintenance, and thus help to insure proper living conditions? On the other hand, it would be necessary for the hospital to organize a permanent nursing staff for the care of the patients and thus allow time for the necessary adjustment of the life of the nurse.

An introduction of such radical innovations into any established order is obviously a slow and difficult task; but the conditions are with us and they must be faced. Without doubt many changes can be made at once in individual schools which will result in an improved training for students; but at best they will be only a temporary improvement. Not until there is a fundamental reorganization of the whole system may we look for the future sound development of nursing education.

In other words, the solution of our present day nursing problem requires courage and foresight equal to that displayed by those who brought to this country pupils of Florence Nightingale, whose mission it was to direct the complete reorganization of the nursing system of that day in order that the public demands for more enlightened care of the sick might be met.

A Little Mothers' League

Mary Margaret Roche, R. N., Superintendent,

Grand Rapids Clinic for Infant Feeding

SINCE the dawn of history more or less futile efforts have been made to improve our methods of caring for the baby. The methods employed have been as diverse as the races inhabiting the different countries.

The infant mortality rate of the United States is a reproach; it is a sad commentary on our lack of enterprise in effecting in what should be our most vital interest, the same advances that have characterized our endeavors in other lines. Perhaps this has been due, in a measure, to the belief that with the baby came the knowledge of how properly to care for it. The fallacy of this belief has been proved at bitter cost to many a mother.

The potential mother of this generation is being given an opportunity to learn some of the essentials of child care through the wise provision of many a Board of Education. We know that child care is a science. Our girls are taught to sew and cook. Is it not equally important for them to know how to keep the baby well?

MOTHER'S UNDERSTUDY

The Little Mothers' League has been Grand Rapids' answer to the question. Many little girls are entrusted with the care of the younger children in their homes. They are expected to bathe and dress these children, to prepare the baby's bottle feedings when mother is busy, to supervise the diet of the older children; in fact, to be mother's understudy. In the years to come they may have little families of their own. They should meet their problems intelligently. They should know that mother's milk is the best food for the baby; they should know that a steady gain in weight is necessary, and that rapid gains resulting in flabby babies are not productive of lasting results. They should be taught that it is just as serious to overload the baby's little body with clothing as it is to have it insufficiently protected. They should learn how much better it is to call a physician promptly and so prevent a serious illness, rather than to wait until the baby is desperately ill. Today the mothers all recognize the need of keeping the baby well. This need, the Little Mothers' League aims to meet. The effect of these redoubled efforts is seen in a lowered infant mortality rate.

LESSONS AND TEACHERS

The Clinic for Infant Feeding began its work with the Little Mothers' League in January 1917. We started with a series of twenty lessons based on the work of Dr. S. Josephine Baker, and Dr. Samuel McClintock Hamill. The lessons were given in five different

schools, after school hours, to classes of not more than fifteen eighth grade girls. The classes were taught by volunteers who had received their instruction from a physician, and their training in giving demonstrations of the care of the baby from a nurse. We assigned two volunteers to a class, in each instance the teacher being a young mother, her assistant a girl just out of college, or school. The pupils were supplied with mimeographed copies of the lessons. A great deal of time was spent in preparing these volunteers for their work, each lesson being gone over in detail, and an opportunity given to question the physician on any points not made clear in the simple presentation of the lesson. Ample time was allowed during the demonstrations given by the nurse for practice as well as questions. The fact that one instructor in each team was herself a mother made the task quite a simple one. The practical work consisted of giving the bath, dressing the baby, making his bed, putting up the formula; the volunteer practising under the nurse's guidance.

GEOGRAPHY VS. BABIES

One of the principals asked that the work be given during school hours and made a place for it. In this school we felt the very best instruction should be given to show just what could be accomplished by the work, and there we placed one of our nurses who had been a teacher before entering the field of nursing. She had a delightful way of presenting her subject and the work became popular. Our superintendent of schools, Mr. William A. Greeson, saw from the first the infinite possibilities in such a course. He even interviewed a number of mothers who felt that the time their daughters spent in learning how to care for the baby was wasted, and should be spent instead, on geography. Mr. Greeson explained that, after all, education did not consist of merely learning the location of different capitols and rivers, but in preparing the girl for life and its duties. If cooking and sewing, to which they did not object, were important, why not the care of the baby?

In 1917, 882 girls took this course. To stimulate the interest, we invited the public to come and see their work. The pupil standing highest in her class was selected to represent her school, and the six little contestants appeared on the platform and answered questions put to them by various physicians. Then each demonstrated what she had learned about bed-making, and about giving the baby a bath. The successful demonstrator was awarded a silver loving cup that was to be the property of the school which she represented until the next year.

The following school year, the Board of Education made room for the course in the curriculum of the manual training department,

in the eighth grades of the public schools, the parochial schools sending their pupils for it, in connection with other work they were taking in this department. The Clinic financed the project, one of our nurses who had had special training in infant welfare work and who had taught for three years before becoming a nurse, was the one selected as instructor. We reduced the number of lessons to ten, with an extra period for examination. The Campfire Girls who took the course were allowed extra honors by their organization.

Our organization had undertaken the work merely as a means of demonstrating its practicability, and its continuance did not seem to be our responsibility. Its future depended upon public opinion, hence every woman's club in the city, the local branch of the Woman's Committee, Council of National Defense, and the boards of trustees of the hospitals supported our request that the Board of Education finance this work, and that it be made permanent. The Board of Education voted to do this, leaving to us the selection and supervision of the nurse who was to do the teaching and the subject matter to be taught.

The present course of instruction has been published in full, in book form. It covers the following subjects:

> Birth Registration and its importance; Sanitation of House; Baby's Room; How to Lift the Baby; the Value of Water, internally and externally; the Bath; the Weight and Development; Play and Exercise; Muscular Development; Teeth; Special Senses; the Diaper and its Care; Baby's Clothing; Fresh Air; Sleep, Bed, Bedclothes; Breast Feeding; Care of Milk; the Baby's Food During the Second Year; Communicable Diseases; Care of Pre-School Age Children.

Time is allowed in each forty-five minute period for demonstrations by the pupils. We feel that the actual performance of these tasks not only makes the work more interesting, but makes it more the pupils' own. It is of real economic value to those Little Mothers, who, during the summer months, go to the various summer resorts to care for children. It also enhances the safety and comfort of their little charges. We have a life-size celluloid doll which can be bathed with soap and water. This lesson is always followed with the keenest interest. One whole period is allowed for an examination, and the following excerpts from the papers of some of the girls will show what they got out of it. The following are from papers written by children of foreign parents.

> "I think that every girl should have a course like this because it teaches us how to care for babies, and if we had a baby our mother could depend on us to take care of it if she wanted to go away. This course we are finishing is of value to ourselves personally because it is something every mother should know and we could not all of us get it at home; it is of great value to the infants because they are helpless and depend entirely on the mother's care; if this was followed to the letter it would form baby's habits regularly as much as mother's."

"These lessons are a great value to me and I am quite sure I could take care of a small baby. I would know what to do with the soiled diapers, how to heat his milk, and the things I was always afraid to do, and that is to pick up a small baby. Now I know just how to do it."

To my mind, these answers speak for themselves, showing whether or not the eighth grade girl is too young to be taught the care of the baby. Too many of them, untaught, are giving this care. The sweet, simple, clean-minded way in which they look forward to motherhood, the feeling of self-reliance and consideration for the helpless they manifest in these answers, show that they have found in this course that which is of even more value than the practical instruction they have received.

So much depends on the teacher. A certain happy combination is indispensable. She should be a nurse familiar with babies and their habits, so that she may speak with sympathy and authority; she should be a teacher in order to present her subject acceptably. Also, being a teacher gives her insight into the problems of those with whom she works and she can enter their rooms, not as "just another of those special teachers," but as one of themselves; and lastly, she must possess the mother instinct to a remarkable degree. Her way of presenting her subject may make it most attractive to the girls. You may say such a teacher exists only in the imagination. You are wrong; she is now working right here in Grand Rapids.

Cutting Down Death Toll Among Utica's Babies

T. Wood Clarke, M. D., Medical Director

CAN you picture an industrial city of 100,000 population in the heart of a rich farming district? Can you see a city of handsome homes in spacious grounds, of wide streets lined by stately elms, and of extensive parks? When you add to this picture of health and prosperity, surrounding hills dotted with prosperous dairy farms, with the milk brought direct by wagon to the house from the farm, and the water supply piped from the heart of the Adirondack Mountains, can you imagine more ideal conditions for the rearing of children?

The above is a picture of the City of Utica at the head of the Mohawk Valley, and such was the mental attitude of Uticians ten years ago. Those of us who thought at all about the infant welfare problem, thought of it as something remote, something involving the great centers of population, but far removed from the garden city of Central New York.

We had a great pity for the babies born in the hot, overcrowded tenements of New York City, babies doomed never to see green grass, or the branches of spreading shade trees; babies to be fed on milk brought hundreds of miles in hot railway trains, twenty-four to forty-eight hours old before reaching the home. We felt appalled at the temerity of people daring to bring babies into the world under such conditions. We thanked God that we with our fresh air, green grass, shade trees, and milk farms almost at our doors, did not have to worry about the health of our babies. With the ideal combination of man-made advantages of the city, with the natural advantages of the country, we had nothing to dread. Our babies were getting the best that God and man could provide.

PRIDE BEFORE A FALL

Then we received a rude awakening. The Municipal League of Utica had a survey made of the city in 1912, followed by a "Know Your City Week". One evening was devoted to infant welfare, and Dr. Goler, of Rochester, was the speaker. Can you picture our astonishment when he told us that whereas in 1911, out of every thousand babies born in hot, overcrowded New York, 111 died during the first year of life, in our healthy city for the same year, the infant death rate was 158? We were faced by the appalling fact that the infants born in Utica were in fifty per cent greater danger of dying during the first year than those born in the East Side of New York!

EXPERIMENTAL REMEDIES

The outcome of this meeting was the appointment of a Committee on Child Welfare, in the Municipal League of Utica. This committee first engaged a nurse to work among the babies of the Italian district of the city during the summer months. Physicians desiring the service of the nurse were to notify the health officer, who would send the nurse. In the first ten days, the nurse had two calls for her services. It was evident that this experiment was a failure. It was then decided to open a "Babies' Pure Milk and Health Station", and the author of this article was placed in charge. This committee has since changed its name to the Baby Welfare Committee of Utica, and has been incorporated. The stations have since become known as Baby Welfare Stations.

In 1912, one station was opened in the dietetic room of the Brandegee School. One nurse was employed, and four physicians volunteered their services. This station was maintained for two months at a total expense of $260.67. The experiment was so successful that the following year two stations were maintained, one in the Brandegee, and one in the Potter Street Schools. The committee was so favorably impressed with the value of the work that in the fall of 1913, it was decided to maintain a station continuously through

the year, and through the courtesy of the Utica Park Board, the first permanent Baby Welfare Station was opened in the dressing rooms of the East Utica Bath House, on October 15, 1913.

GROWTH OF THE WORK

The work has grown steadily from that date until at the present time the committee maintains four permanent Baby Welfare Stations, employs seven full time trained nurses, and has a medical staff of seven physicians, all of whom, with the exception of the Medical Director, are paid a salary.

At first we made use of such rooms as we could get free of rent: dietetic rooms of schools, the dressing rooms of the public bath house, and two rooms in a lodging house of the Globe Woolen Mills. When the Utica Public Library opened a branch in the West End of the city, two rooms were set aside for our use, and today one of our most successful stations is held in the library building. A second is held in conjunction with a Day Nursery of the Junior League, and the other two are in stores rented for the purpose. Our prenatal nurse has had her office in the Utica Dispensary, and acts as clinic nurse for the obstetric clinic there.

The work was carried on entirely by private subscription until 1915, when the city appropriated the sum of $1,000.00 towards the work. The following year the city gave us $2,000, and the city appropriations and subscriptions have increased until the budget for the present year is $12,000, of which $6,000 is appropriated from city funds by the Board of Estimate, and $6,000 is raised by private subscription.

The work of the committee includes pre-natal work, infant welfare work, pre-school work, and Little Mothers' League.

PRE-NATAL WORK

The pre-natal work consists in the visiting of expectant mothers by trained nurses, who instruct them in all the many things which they should know in regard to their own health, and in the care of the coming baby. The nurse escorts the mother to the Dispensary for examination by a physician when she has no private physician of her own, or to her own physician's office. She visits the patient every two weeks during her pregnancy to give advice and instruction, places at the house a package of sterile dressings and towels for the use of the doctor at the time of confinement, and, where necessary, supplies a sample outfit of baby clothes containing one of each article required, and teaches the mother how to duplicate them. She attends the mother after the confinement, instructs her in the care of her baby, and when the latter is one month old, she refers them to the Baby Welfore Station for further care.

INFANT WELFARE WORK

The Infant Welfare work is carried on by the physicians and nurses of the Baby Welfare Stations. Twice a week a clinic is held in each station, which is attended by the physician in charge of the station. At these clinics the babies are weighed by the nurse, or by the visiting member of the committee; they are examined by the physician who instructs the mother in the care and feeding of the baby. If the baby is ill, it is referred to a family physician, or to one of the hospitals. Within twenty-four hours after the baby has been brought to the clinic the nurse visits the home and instructs the mother, giving practical demonstrations as to the care of the baby, and in the preparation of its food. If the baby is not doing well, she visits it as frequently as the circumstances require. Each baby enrolled in the station is visited at least once a month. Each baby is supposed to be brought to the station at least once a month to be weighed and examined.

PRE-SCHOOL WORK

The pre-school work, the newest development of child welfare work, was started in Utica last year. It is supposed to fill in the hiatus which has existed between the time the baby graduates from the Infant Welfare Station at two years of age, and the time when it comes under the supervision of the school nurse at about its sixth year. A special physician has been engaged to care for these children for whom a pre-school clinic is held once a week in the various stations. The children are brought to these clinics four times a year for examination and advice. If anything wrong is found, the child is referred to the family physician, or to the Dispensary; the physician, or Dispensary, is notified of this and if the patient does not arrive, the nurse follows up the case, and tries to see that proper care is provided. Nutrition clinics and mothers' meetings are held in which the parents are given general instructions as to the proper care and feeding of children.

LITTLE MOTHERS' LEAGUE

Little Mothers' Leagues are held in the school houses in the more congested districts. The Leagues are clubs of girls between the ages of twelve and fourteen. They elect their own officers and conduct their own meetings. At each meeting a physician or a nurse instructs the members in some aspect of infant welfare work. At the next meeting, each girl writes her view of what she learned at the last meeting. An examination is held at the end of the course, and all girls who pass the examination, and have attended the meetings regularly are awarded diplomas and Little Mothers' pins. Each member of the League is supposed once each day to do some act which will improve the health of some baby.

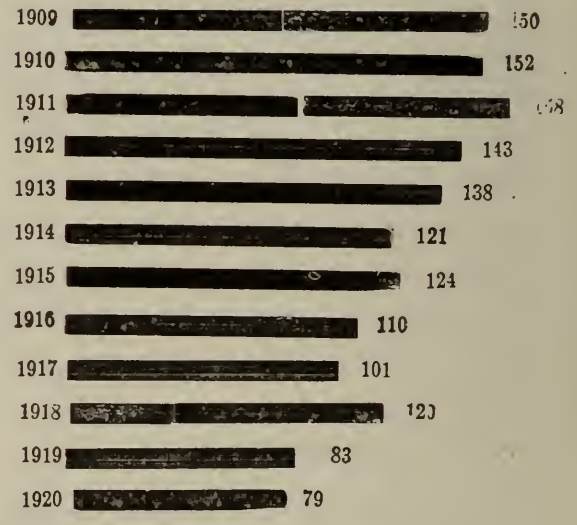
The results of these Leagues are threefold. The little mothers are taught how to care properly for babies left in their charge; they disseminate the knowledge which they have learned to their parents and to their married sisters; and as a result of the fundamental knowledge acquired in the League, they are better prepared to become intelligent mothers themselves when that time comes.

ENCOURAGING RESULTS

The result of this work is shown by the improved health among the babies in the poorer quarters of Utica. When the stations were first opened most of the babies admitted were sickly, pale, wizened, pitiful little specimens. Today one visiting the clinics sees congregated there from twenty to forty specimens of perfect infancy. Occasionally now one sees a sickly child among the healthy, but the sick ones are becoming rarer as the work goes on. The children who ten years ago were condemned to start life handicapped by improper care and feeding during infancy, are now launched into the sea of life with strong, healthy constitutions.

REDUCED MORTALITY RATES

The results of the work are also shown by the infant mortality rate of the city of Utica as taken from the records of the State Department of Health. In 1911, the year before the inauguration of this work, out of every thousand babies born in Utica, 158 died before the end of the first year. In 1920, out of every thousand born, 79 died in the same period. The infant death rate in Utica has been cut exactly in half in nine years. A saving of 79 lives out of every thousand in a city which has 2,500 births a year, means an actual saving of nearly 200 lives each year. In 1911, when Utica's death rate was 158 and New York City's, 111, we set as the goal of our ambition the making of Utica as healthful for the baby as New York. This has been accomplished, for, whereas in those nine years the New York City death rate has been reduced from 111 to 86, during the same period the infant death rate of Utica has dropped from 158 to 79.

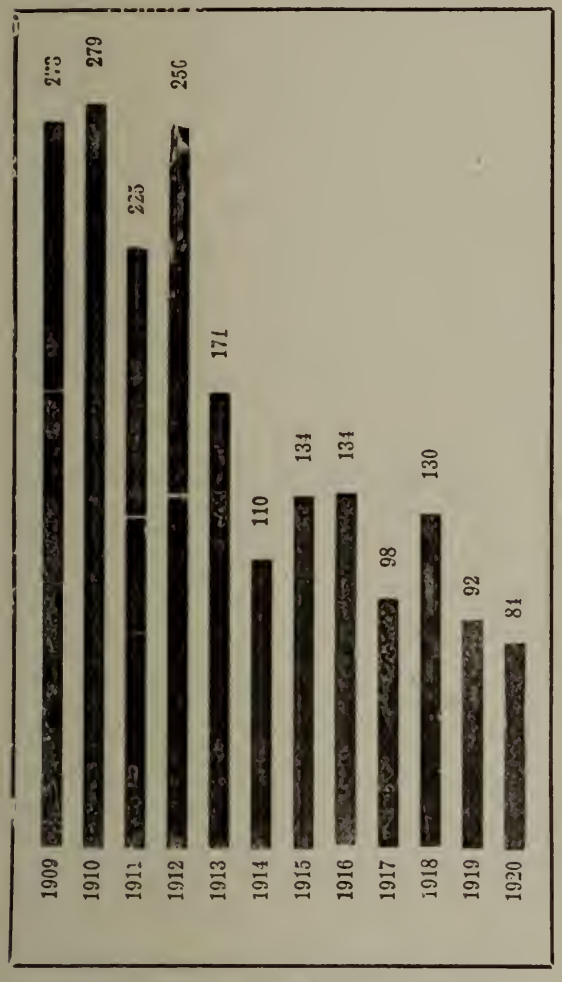


Infant Mortality In Utica.

Note rise in infant death rate prior to organization of Utica's Baby Welfare Committee in 1912 and steady decline since that year, except in 1918, the year of the influenza epidemic.

Even more striking is the change in the death rate during the hot summer months. For the four

years' prior to 1913, the infant death rate in Utica for the months of July and August averaged 258 per thousand births. For the same months of 1920, the death rate was 84 per thousand. The epidemics of summer complaint, properly named dirty milk poisoning, which a decade ago wiped out so many of our infants during the hot months, have been practically abolished in this city.



Summer Infant Death Rate In Utica.

Deaths per 1,000 births for months of July and August.

In October, 1918, the terrible scourge of influenza swept over Utica. The city was appalled at the toll of death, and yet, the infant death rate for the month of October, 1918, was 217, far below the average infant death rate for any summer month of the decade previous. The scourge of influenza which created such excitement was less fatal to our babies than the ordinary, unnoticed annual scourge of summer complaint which was accepted ten years ago as the normal course of events, and has now become obsolete.

JUSTIFIABLE PRIDE

Today the citizen of Utica can hold up his head with pride when infant welfare is mentioned. We can boast of an infant death and sickness rate which compares favorably with that of any city in the country. Our city is as healthy for the baby in midsummer as in midwinter. The unnecessary slaughter of the innocents is a thing of the past.

What has brought about this great change? Several factors are at work. The State Department of Health, by its campaign of education had done much. The City Board of Health, by cleaning up the milk supply, by better control of contagion, and by the employment of public health nurses has been a great aid. But with due respect to the State and to the City, it must be conceded that a very considerable proportion of the improvement in the living conditions of our babies is due to that band of devoted ladies, the Baby Welfare Committee of Utica.

MOTHER AND CHILD
A Magazine Concerned With Their Health

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OCTOBER, 1921

The Annual Meeting

This year the American Child Hygiene Association returns for its annual meeting to New Haven, where twelve years ago the Association was formed.

In this issue of the magazine there is given an account of various attractions which New Haven offers. Town and Gown are both represented. Those who are interested in school medical inspection will be glad to see how the University safeguards the health of the student body in Yale. The physicians will find the Medical School branching out on new lines with the professors on a full-time basis. Dr. Edwards A. Park is this fall beginning his work in the University, with a most carefully selected group of young men, interested especially in research.

The program is full of meat, and has been most effectively arranged by a committee under the chairmanship of Dr. Richard Smith of Boston. The Federal Government will be represented by Brigadier General Sawyer who will speak on National Coordination, a subject to which he has given most earnest attention. The state Divisions of Child Hygiene will be quite generally represented. A special time has been set aside for them.

Last year in Doctor Van Ingen's presidential address he laid upon every member of the Association responsibility for its success. He asked each one of us to pledge ourselves to the limit of our ability. Help by coming to the meeting. Help by renewing your membership.

Forthcoming Election

At the New Haven meeting there will be sixteen members of the Board of Directors to be elected as well as officers for the ensuing year. The future work of the Association depends in very large part upon the active interest and work of the Board of Directors. The Nominating Committee appointed at St. Louis last year is desirous of strengthening the Board of Directors by adding a number of non-professional people who are interested in child welfare and whose names would add strength to the organization. Suggestions for Directors and officers are requested

from members of the organization and should be sent at once with the necessary information to the Chairman of the Nominating Committee, Dr. Borden S. Veeder, 608 Humboldt Bldg., St. Louis.

The New Year Book

THE Transactions of the Eleventh Annual Meeting of the American Child Hygiene Association, have been sent to its members who find therein justification for Doctor Holt's dictum that these reports constitute the most valuable year book published in this country on maternal and child welfare. The papers which were read at the annual meeting in St. Louis last fall, are given, and the discussions on these papers in which the members, coming from far and near, present their individual viewpoints. The Transactions indicate not only where we stand on child welfare, but in which direction we are moving. They show where new trails are being blazed, as in the descriptions that are given of nutritional studies; of standards and methods of health work for children of pre-school age, and for children with bad hearts.

Tables and statistical data are presented in full in the volume, and are invaluable for purposes of reference. An example of this is to be found in the analysis by the late Frederick S. Crum, Ph. D., of Dutch Vital Statistics, with special reference to infant mortality.

The chief points brought out in the Round Table Conferences are here set forth, together with the conclusions arrived at by those who are forging ahead on special types of work, whether it be "Rural Health Problems," "Divisions of Child Hygiene" or in "Nursing and Social Work."

The Reports of Affiliated Societies occupy nearly one-fourth of this volume of the Transactions, and here, for instance, Connecticut tells her neighbors across the continent of work which has been undertaken, and with what measure of success. Some of these societies indicate the pitfalls they have encountered so that others may not need to learn the same lessons in the hard school of experience. This takes courage of a high order. Dr. William H. Welch has said that one of the purposes of the Association is to formulate as definite a program as possible as to where and how efforts should be concentrated in order to secure the best results in the shortest time and in the most economical way. No other feature of the work of the Association is of greater value in furthering this aim than the publication of the reports of these Affiliated Societies.

This year the Transactions have been sent only to those members of the Association who indicated a desire for a copy. Any member who has not received the volume may secure one by notifying the office of the Association.

The Day's Work

THE HEALTH INSTITUTE

A HEALTH Institute, to be held in New York City from November 8th to 11th, will constitute one of the features of the fiftieth annual meeting of the American Public Health Association which convenes the following week, November 14th to 18th. The Institute is sponsored by the American Public Health Association, the Health Department of the City of New York, the New York State Department of Health, and the National Health Council, with the cooperation of many other organizations.

The purpose of this Institute is to afford to public health workers an opportunity to see the operation of established methods applicable to various phases of public health. A fee of ten dollars will be charged.

The section on the Hygiene of Mother and Child has as its chairman Dr. S. Josephine Baker. Plans have been made for the following:

Demonstration of hygiene in the public schools, including morning inspection, routine classroom inspection, physical examination, and consultation of parents.

Demonstrations of the work of the Health League, and of the Little Mothers' Leagues.

Visits will be made to one of the Baby Health Stations of the New York City Department of Health; to the Bellevue Hospital Baby clinics and the school of Midwifery; to heart and other special clinics including those for the pre-school child, and to nutrition classes.

Further information may be obtained from the Director of the Institute, Dr. D. B. Armstrong, National Health Council, 370 Seventh Avenue, New York City.

COURSES IN HEALTH EDUCATION

The School of Public Health, conducted by Harvard University and Massachusetts Institute of Technology is offering a course of study to provide the professional training necessary to teach or direct the hygiene instruction in the public schools, and to correlate the various health activities of the public school system in the most advantageous way.

The course provides a thorough background for health work in the public schools and should be useful to the school nurse, the teacher of hygiene, or teacher of physical education, equipping them for the better accomplishment of their present work, or for a larger and broader field of professional activity.

Students will be admitted to the courses if they are high school graduates, and if, in addition, they are normal school graduates, graduate nurses with public health training, graduates in physical education, or graduates from an approved college. Students must have had at least one year's experience in school or public health work.

HEALTH BILLS

During the special session of the 67th Congress, 121 bills or resolutions out of the more than 11,000 that have been introduced, have dealt with some phase of public health. This information comes from the National Health Council, which has issued eleven bi-weekly Legislative Statements since April, when the special session was called. Statement No. 11, which is dated August 25th, is a twenty page review and index of all this health legislation. Eighty of the 121 bills have been abstracted and discussed at length and their progress carefully followed in the eleven statements. The other 41 bills were considered of indirect importance, and so were merely cited. These reports are prepared and distributed by Mr. James A. Tobey, Washington Representative of the National Health Council, 411 Eighteenth St., N. W., Washington, D. C. Copies are supplied to non-members of the Council at cost price, twenty cents an issue.

CANADIAN CHILD WELFARE CONFERENCE

The first Annual Conference of the Canadian National Council of Child Welfare was held in Montreal on the 29th and 30th of September. In the Child Hygiene Division, Dr. W. A. L. Styles of the Child Welfare Association of Montreal told of the Child Health Train which has been travelling through Quebec; Miss Mary Power, of the Ontario Child Hygiene Bureau, gave an account of the Government Child Health Clinic in Ontario. Health Inspection in the School was presented by Miss Eunice Dyke; and The Infant Soldier was the subject of a paper by Dr. W. W. Chipman. The open discussion was led by Dr. C. J. O. Hastings.

The first evening open meeting, presided over by Premier Taschereau, began with an address by Dr. J. A. Amyot, the Deputy Minister of Health. Dr. Helen McMurchy, chief of the Children's Division, Federal Department of Health, was chairman of the second evening meeting, at which Dr. Ruggles George of the Canadian Red Cross spoke on Milk as a Vital Food Product; the Reverend Peter Bryce spoke on Some International Aspects of Child Welfare; and the Reverend Ernest Thomas on the Spiritual Development of the Child and Social Problems.

MAKING THE THIRTY PER CENT FIT

Jeanie Minor, Assistant Secretary of the New York Child Labor Committee reports that about 70 per cent of the children to whom working certificates are refused because of physical defects return later with the defects removed or remedied. A specially trained worker was appointed by the employment certificate office to follow up the other 30 per cent, and the experiment has shown that this percentage can be cut down to a well-nigh irreducible minimum. (*The Family,* June, 1921.)

DR. PETERSON'S NEW WORK

Dr. E. A. Peterson has resigned from the Health Service of the Red Cross and is returning about October 16, to Cleveland, where he was formerly Medical Director of the public schools.

In announcing Dr. Peterson's acceptance of the directorship of the newly organized Cuyahoga County Public Health Association, Dr. Bishop, President of the Welfare Federation of Cleveland, says, "This is the only place in the country where all of the privately operated health agencies of a county are brought together under one head for the purpose of forwarding the health work of the community and giving the right sort of support and cooperation to the public health agencies. The people of Cleveland are its chief beneficiaries."

In an editorial comment, the Cleveland Plain Dealer of September 21, says that Dr. Peterson's acceptance of the post means much for the success of the organization.

COUNTRY VERSUS CITY CHILD

Professor Mabel Carney, of Columbia University, has recently completed a survey showing that for the 8,000,000 children attending one or two-room rural schools, the average school term is 137 days, and the average daily attendance 65 per cent., as compared with 184 days and 80 per cent. for city children; and that rural teachers are not only poorly paid but poorly prepared. Opportunities of the two groups of children for high school education compare as one to six, 90 per cent. of the country children never going beyond the rural school. The death rate of rural school students is five times as great as that of children in the schools of New York City, and cases of uncorrected physical defect are far more numerous among the former. (*The Literary Digest, August* 20, 1921.)

COUNTRY SCHOOL DENTISTS

Since 1918 nearly 45,000 school children between the ages of 6 and 12 have been given free dental treatment and instruction by the Department of Medical Inspection of the State Board of Health of North Carolina. A number of dentists on a whole-time salary basis are sent, with portable equipment, to the public schools throughout the state, especially in the country districts. This is the first effort of its kind to be made in the United States.

The State has gone further in providing surgical operations for children in remote districts who have tonsil and adenoid trouble. Several children needing operations are grouped together and a specialist from a near-by city is requested to go and hold a clinic. A school building, a new courthouse, or any suitable place is equipped as an emergency hospital, and nurses employed by the department are placed in charge. Clinics of this kind

have been held in more than 40 counties, reaching children of every class. More than 3,000 operations have been performed on school children with only one death, a record only once surpassed by a hospital in the United States. (University of North Carolina *News Letter,* September 7, 1921.

PROVISION FOR EXCEPTIONAL CHILDREN

In the public schools of Oakland provision for exceptional children is made through 83 special classes for children who would be misfits in an inflexible grading and promotion system. More than 2,000 children enter these classes each semester. The classes are of four kinds: A typical, for mentally retarded, three years or more behind in grade; special limited, for dull or slow pupils; opportunity classes, for pupils of good mental ability, but who are in low grades because of illness, etc.; and accelerated, for pupils of superior capacity. (*School and Society,* July 16, 1921

TEACHING HANDICAPPED CHILDREN

The need for education of crippled children, who have heretofore been given special physical care only, is the subject of an article in The Nation's Health of August 15, by Dr. Alexander E. Horwitz, who foresees that if orthopedic hospitals are not also educational, mental handicap will augment physical defects. Only four state institutions for crippled children at the present time give educational as well as medical attention, he says; The Massachusetts Hospital School, the Nebraska Orthopedic Hospital, the Minnesota State Hospital for Crippled and Deformed Children and the New York State Hospital for Children. Any one of our large cities could furnish the full quota of 700 children cared for by these four institutions. The Spaulding School of the City of Chicago is mentioned as giving crippled children varied courses in shopwork, etc., at a per capita cost only slightly more than that of educating subnormal children. In his plea for public institutions of this type Dr. Horwitz argues that crippled children, when segregated, can be taught more systematically, are saved from depressing comparisons with able-bodied schoolmates in work and play, and become accustomed to a frank and healthful attitude about their infirmities.

MICHIGAN PROVIDES ANTITOXIN

A recently enacted law of the State of Michigan, provides for the furnishing and distribution by the State Commissioner of Health of antitoxin and other biological products for the prevention and treatment of diphtheria, and appropriates for the purchase and manufacture of such products the amount of $40,000 for the fiscal year ending June 30, 1922, and $75,000 for the following year. (*Public Health,* Published by the Michigan Department of Health, July, 1921.)

INTERNATIONAL CONGRESS OF EUGENICS

The Second International Congress of Eugenics was held in the American Museum of Natural History from September 22nd to the 28th. The first Eugenics Congress assembled in London in 1912. The opening address, on the history of the eugenic movement from its institution by Francis Galton, was delivered by Major Leonard Darwin, (son of Charles Darwin), President of the Eugenics Education Society of Great Britain; and the progress which has been made in eugenics in America was reviewed by Dr. Charles P. Davenport.

The program was divided into four sections. Dr. Lucien Cuenot, of Nancy, France, one of the great students of heredity, gave the leading address in the first section, dealing with the results of investigations in the domain of pure genetics in animals and plants, and of studies in human heredity. Dr. Herman B. Lundborg, of the University of Uppsala, Sweden, an authority on psychiatry and neurology, gave the chief address in the second section, which dealt with the factors influencing the human family and brought forward data bearing upon improved and unimproved families and showing the persistence, generation after generation, of the best as well as the worst characteristics. Dr. Lundborg is the author of an investigation similar to that made of "the Jukes" by Dugdale which has been characterized as "the most comprehensive and thorough examination of a family that has ever been made." In the third section concerned with racial differences and their significance, Dr. V. de Lapouge, of Poitiers, France, gave the leading address. Differences in racial resistance to disease were also discussed in this division. Section four, (in which the main address was by Major Darwin), discussed eugenics in relation to the state, to society, and to education, and its bearing on the various social problems and movements of the day.

A large number of scientific bodies and institutions, some as remotely situated as the University of Punjab, India, sent delegates to the Congress, the most representative workers in the field of Eugenics from all over the world being present. The Carnegie Institution made a generous grant toward the expenses of the Congress.

For any information concerning the Congress, address Dr. C. C. Little, Secretary-General, American Museum of Natural History, New York City.

BABY SAVING IN CHICAGO

The Infant Welfare Society of Chicago reports a 64 per cent reduction in their death rate over a period of 10 years. This means saving 27 more babies per 1,000 cared for by the society. The cost is less than $1,000 per year per clinic. *The Public Health Nurse,* August 1921.

EYE CLINICS IN SCHOOLS

There are nine eye clinics in the New York City schools, all but one of which are located in the school buildings. Only children unable to pay a private physician are accepted for treatment. The clinics are closely connected with the school medical inspection service. The duties of the clinics are to detect and treat contagious diseases, correct refractive errors for school children not under private treatment and examine candidates for the sight conservation classes and classes for the blind. (*Bulletin of the Department of Health, N. Y. City, June 25, 1921.*)

IMPROPER DIET HANDICAPS CHILDREN

The traveling clinic of the Michigan State department of health has in recent months visited 25 counties, in both the upper and lower peninsula. It has examined 5,211 children of which number 65 per cent were found to be under weight. In the majority of cases the undernourishment was due not to lack of food in the homes, but to the fanciful appetites of the children, and misunderstanding on the part of the parents as to what constitutes a proper diet. (*Journal of the American Medical Association, 1921.*)

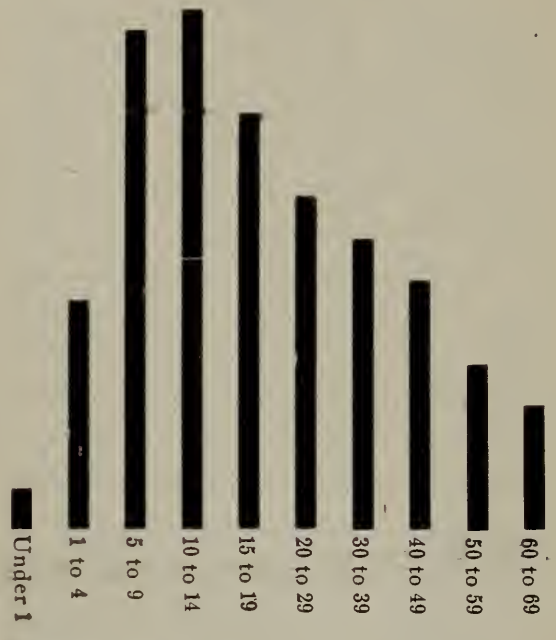
NEW CHILD WELFARE QUARTERLY

The first issue of Alabama Childhood, the official bulletin of the state child welfare commission, which is to be published quarterly, appeared the last week of July.

Accidents in Childhood

Myra M. Hulst
Statistician, Health Service,
American Red Cross, Washington, D. C

THE following chart shows that out of every 1,000 deaths of children between the ages of five and nine, 167 are due to accidents; of children between ten and fourteen, 177.



Number of Deaths from Accidents per 1,000 Deaths from all Causes, at Various Ages.

The following table shows the percentage of deaths from accidental causes, according to the Bureau of the Census, Mortality Statistics, 1917.

Cause of Accident	Under 5 years	5 to 9 years	10 to 14 years
All causes of accidents..	100.0	100.0	100.0
Burns	40.2	21.9	9.3
Accidental Drowning.....	5.2	14 5	22.0
Vehicles	10.5	39.0	32.5
Falls	8.1	6.7	6.9
By Firearms.....	1.3	4.3	11.5
Poisoning	21.1	3.9	3.6
All others	13 6	9.7	14.2

The Foreign Field

England

"DEEDS, NOT WORDS"

In a letter of July 28th, 1921, Miss Halford, Honorary Secretary of the National League for Health, Maternity and Child Welfare, says:

"Any number of good, useful institutions have been obliged to close down lately and there will be more in the near future, owing to the absolute lack of funds that prevails everywhere and to the Government's insistent call for economy. No doubt it is necessary, but surely health is the last thing on which a nation should economize. It is not as if child welfare work had not fully justified the comparatively small amount that is spent on it. Our infant mortality figures prove that. Last year's rate of 80 per thousand births is, to my mind, a wonderful achievement, being a halved rate in 15 years* Still more remarkable are the figures during the present hot spell, the worst we have ever known here and worse even than 1911. Then, during the third quarter, the infant mortality rate, chiefly from diarrhoea, ran up to 201, but during the last eight weeks of this year, the hottest time, it has averaged only 56. That means that mothers know what to do, not that they care more, and that they and the doctors at the centers are more on the lookout for the least sign of things amiss. Of course, we are not out of the woods yet, for the highest rate comes when the cooler weather and rain sets in, with an increase in the fly pest. Still, we cannot fail to beat all previous records, money or no money."

*It is interesting to note that the years between 1914 and 1920 when the infant mortality rate fell from 105 to 80, the number of infant welfare centers increased from 340, in 1914, to 1,937, in 1920.

Daylight and the Children—The Board of Education of England and Wales, has recently requested the Local Education Authorities to ascertain the effect of daylight saving summer time, during the current year, on the health of school children, and report to the board not later than October 1 of this year. It has been stated that as a result of the longer daylight period, children do not go to bed at the usual time, and thus are getting an insufficient amount of sleep. (*National Health*, June, 1921.)

Scotland

SCOTTISH NATIONAL ASSOCIATION OF HEALTH VISITORS, WOMEN SANITARY INSPECTORS AND SCHOOL NURSES.

The Second Annual Conference of this Association has recently been held in Dunfermline. Perhaps the most interesting part of the conference was the visit to the Carnegie Dunfermline Trust Institute, of which Provost Norval said

to the visitors: "Amongst the activities of this experiment the care of the child has always taken first place. One of the first duties of the state should be to see that the children, the future citizens, should get every chance to become intelligent and healthy members of the community. This care of the child should be shared by parent and state. Parents should be educated to a greater appreciation of their responsibility—if not by persuasive means, then by some more drastic and compulsory methods. Nature secured a healthy and virile population in barbarous times by barbarous methods, by the ruthless elimination of the unfit, but life has become so highly complex and artificial that no longer could nature be allowed to work in the old way. Scientific methods must perforce be enlisted if they hope to build up, under modern conditions, a strong, healthy nation. The health visitor was getting to be the rule, and not the exception, in all progressive communities."

Dr. Alister Mackenzie, Chief Medical Officer, Carnegie Dunfermline Trust, read an interesting paper entitled, "The School Clinic in the Health Campaign," in which he emphasized the watchwords of today: 1. Search; 2. Treat; 3. Prevent; 4. Enlighten. He gave the modern interpretation of preventive public health work, dealing with the functions of Infant Clinics, School Clinics, Industrial Clinics, Schools for Mothers, and, related to these, the need for and methods of teaching health matters to all scribed the working of the School Clinic in Dunfermline, particularly emphasizing the work of the health visitor in connection therewith."—*National Health,* Vol. 14, p. 312, July, 1921.

India

"Maternity and Child Welfare in India" is the title of a quarterly review, the first number of which has just appeared, published by the Lady Chelmsford All-India League for Maternity and Child Welfare. The League includes Indian women and European women resident in India. It has branches in Delhi and Simla and in Bengal, Madras, Bombay and the Punjab. It tries to improve conditions for children by opening maternity homes and hospitals, organizing exhibitions, training health visitors for work "behind the purdah," and educating the midwives. A committee of English and Indian ladies in Madras is working to provide enclosed gardens within the city where mothers and children can take the air. — *London Times.*

Medical inspection is soon to be inaugurated in the public schools of Bombay Presidency, with six inspectors. The scheme was approved by the government in 1913, but was not put into effect because of the war.

France

BABIES' STREET FAIRS

"THE great city of Paris has always had its little street fairs, since the days when the camp of the Gauls on an island in the Seine was entertained by groups of wandering vagabonds, with monkeys and bears.

"Somewhere in Paris, every night for centuries, a blaze of light and a blare of noise have called Parisians to music and dancing and strange sights. The fairs move from quarter to quarter; sometimes you find them in Montmartre, sometimes in Passy, sometimes in the grass-grown moats outside the city walls. But there is always at least one fair, and its gypsies, its trained horses and dancing bears and merry-go-round of saddled pigs, its crowds of youths and maids and stout, middle-aged couples were always the same—until last week.

"Now there is a new kind of fair in Paris, outside the Porte Maillot, and nearly ten thousand Parisians are visiting it every day. On a sunny afternoon the busses and subway trains leading toward it are crowded; and throngs wait their turn on the little trains pulled by toy steam engines that go through the woods of the Bois de Boulogne to the ring of orange and green tents that house the American Fair.

"'Sauvons les Bebes', the banners read, flaunting their colors across the forest road that passes little lakes and the wire-fenced pools where seals play in the water. 'Save the Babies' is a phrase that echoes in every French heart since the war, for the French know what only a few Americans yet realize, the terrible death-rate of the children of the western nations; and the Fair that shows the French what the Red Cross is doing to save American babies needs no music to crowd its tents.

"A quarter of a million babies die every year in America; one baby in every ten born, and most of these deaths are as needless as those of King Herod's victims. In France the destruction is even more merciless; since 1914 the total death-rate has exceeded the birth-rate by more than 50 per cent.; and the babies are dying in even greater numbers than ours.

"Deaths on the battleground of wars appal and terrify the nations; ten million men have been killed by cannons and bombs and poison gases, and the whole world is aghast. But the slaughter of the babies in their cradles has been greater; it continues every day, always through the peaceful years. It is unnoticed; no headlines shriek the news, no newsboys cry it through the streets. It is a matter of dry statistics, always uninteresting. Quietly, while no one cares, it destroys the races and the nations, while the few who see the bloodshed cry like Cassandra on the walls of Troy, and struggle

with banners and posters and colored bunting, against the placid indifference of parliaments and peoples.

"Therefore, the new Fair, in the Jardin d'Acclimation, outside the Porte Maillot of Paris. It would not be a new thing in America, where the efforts of the Children's Bureau and the Red Cross and the Public Health Department and many local organizations have long tried to arouse the American people to a genuine effort to save the babies. But France had not seen such a thing until the Americans came. Perhaps the memory of the astonishingly tall, broad American soldiers who marched through the streets of Paris gives keenness to the interest with which French mothers hurry to learn how babies should be fed and clothed and cared for. Perhaps, when America has known the bitterness of years of war and has seen the stature and strength of her people visibly declining, she will be aroused by the slogan, "Save the Babies".

"At any rate, here is the new Fair. A circle of green and orange tents around a children's playground. It is such a playground as most American cities have; a sandy space enclosed by wire fencing and wildly alive with swings, "teeter-boards", slides and bars, all being used with enthusiasm by groups from various Paris schools. Outdoor sports are a new thing in France; even the names for them are English, and a large crowd watches the children playing and takes the pamphlets that explain why such exercise is good for children. There is no question that the children love it; few things that are good for us are received with such enthusiasm.

"Behold beside the playground the Guignol, the Punch-and-Judy show that is part of a French fair as popcorn is a part of the American circus. The benches under the open tent are crowded with excited children; a thick fringe of smiling parents and nurses surrounds them. The redoubtable Punch appears on the small velvet-draped stage and slugs the policeman in the immemorial manner—but, O, innovation! the reason for the slugging is new and delightfully American.

" 'Do you brush your teeth after each meal?' says Punch, and the children applaud the murder of the abhorrent gendarme who doesn't.

" 'Do you ever sneeze without covering your mouth,' Punch demands of the agitated audience, and "No!" the children roar. Thus the antituberculosis campaign is sugar-coated, while the next generation of Paris swallows the pill and cries for more.

"In the other tents are the exhibits of proper clothing for babies and pregnant women. This is one of the instances in which America can teach dressmaking to the French; and the novelty of clothes made for health and com-

fort, and of layettes sans buttons and chafing seams and unnecessary binding of baby's legs and arms, is examined by lingering crowds.

"Then there is the exhibit of foods that should be fed to growing children. If every American mother looked at these with the attention these French mothers give them today, America would no longer stand below the sixteen other nations in the chance of life she gives her babies. The glass cases displaying the bread, the milk, butter, eggs, fresh fruit and green vegetables startle the French into exclamations.

"'You do not feed children so much as that!" and "Do you give no coffee, no beer, no wines? You do not feed your children cheese, or pickles?'

" 'No,' the attendant food-expert says, handing out the pamphlets. 'All those are very bad for children.'

"Paris will not take too kindly to oatmeal; it was better received in the cities of the north, where the American Red Cross Fair has been running during the past months. For this Fair, the only one of its kind in France, travels from place to place like its sister demonstrations of the Children's Bureau and others in America.

"Like the traveling circuses, it brings strange things and a new current of novelty into stagnant lives; it leaves behind it a scattering of ideas that will save many thousands of young lives. For beyond the tent where an American woman dentist demonstrates on doubtful but excited patients the proper care of children's teeth; beyond the glass house where, every day, in the center of an absorbed crowd, three babies from the poorest quarters of Paris receive a scientific bath and are properly dressed in new clothes by a trained nurse; beyond the tent where a map of the world is almost hidden by the crossing threads showing the school-correspondence work of the Junior Red Cross, there is the chart-room where the deaths of babies become large black figures.

"For every thousand live births in America and France the figures of deaths run: America—1915, one hundred; 1916, one hundred and one; 1917, ninety-four; 1918, one hundred and one. France—1915, one hundred and forty-one; 1916, one hundred and twenty-one; 1917, one hundred and twenty-two; 1918, one hundred and thirty-eight.

"It is not a record for America to be proud of, but it is one to drive deep into every French mother's heart the desperate need for saving the babies. Such Fairs as this will perhaps in time teach America the same lesson." (*Rose Wlider Lane in the Red Cross Bulletin, Volume 5, Number 29, July 18, 1921.*)

Recent Literature on Mother and Child Welfare

Book Notice

Infantile Paralysis. Published by the Chicago Visiting Nurse Association, 104 South Michigan avenue, Chicago. September, 1921.

This pamphlet contains "A Message to Parents and Patients," prepared by the Committee on After-Care and Study of Infantile Paralysis of the Visiting Nurse Association of Chicago, and "A Statement in Regard to Epidemic Poliomyelitis" prepared by the Committee on Public Health Problems of the Chicago Institute of Medicine. These two articles are the result of repeated requests for a statement that would serve in some measure to properly instruct people asking for advice or reassurance.

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A Posture Poster

Drawing by Anna Milo Upjohn

Chin in—Chest up—Waist in—
Weight on the balls of the feet.

Now see how well you look!

Copyrighted by the American Red Cross.
See Page 491.

MOTHER AND CHILD

A Magazine Concerned With Their Health

VOL. II NOVEMBER, 1921 NO. 11

What the Babies of the World Owe to France

Benjamin Broadbent*

IT is a good thing sometimes to pause and look back over paths that have been traversed, and it is not uninteresting to trace back to its source some streamlet that has little by little and by many tributaries become a river. Both the metaphors are needed to give a true impression of the gradual development of the modern movement, known by many different names, concerned with the welfare and protection of Motherhood and Infancy.

In nearly every country in the world, there is now some public organization which has for its object the safe-guarding of mothers, and the protection of infant life. These organizations are new; it is safe to say that thirty years ago there was not in existence, even in the most elementary form, anything corresponding to them. To say this is not to imply for a moment that motherhood was neglected, or that infancy was uncared for; the laws of nature, the heart of humanity in parenthood, were as strong and, for the most part, as effective then as now. Indeed it has been one of the strongest objections to organized effort to help mothers and to save babies that organization may possibly tend to weaken parental responsibility and so defeat its own object. Up to the present it is certain that this objection is not countenanced by the facts, the whole tendency of the movement being to strengthen the consciousness of natural duty. Nor must it ever be forgotten that the public effort for the welfare of infancy is a reaction against artificial and unnatural conditions caused by modern developments of civilization. It is a movement back to natural law. These considerations however are hardly germane to the purpose of this paper. The organizations, new as they are, exist and they are constantly growing in strength and in usefulness; the question is, how came they into being, whence their

*An article by Mr. Broadbent, formerly Mayor of Huddersfield, England, appeared in Mother and Child, Vol II., No. 7, p. 298, July, 1921.

source, and what their course?

There can be no question that to France belongs the credit of the earliest work for the prevention of infant mortality. It was in Paris that in 1905 was held the first International Congress connected with the movement. This was the first occasion which brought together from all parts of the world those who up to that time had in various ways become interested in the saving of infant life and health. Hitherto there had been no such gathering in any country and to most of those present the subject itself was quite new—the greater number came to Paris to learn. What was it that France had to teach the world in 1905?

The Congress in Paris was the confluence of many streams; it was the meeting place of influences which had already been at work. There had been for many years in France a gradually accumulating stock of experience and knowledge in "La lutte contre la Mortalite Infantile". There is no doubt that the stationary condition of the population of France caused some of the more far-seeing students of social and political questions to take alarm at the future of the country. The margin between the loss of human wealth by death, and its reparation by birth was becoming more and more limited; in some of the great French towns the population was only kept up by immigration from the country districts. The only practical remedy at that time seemed to be the better preservation of the newly-born. Hence arose various scattered and sporadic attempts to prevent the deaths of infants. Doctor Variot in 1892 set up the first "Distribution de Lait" in Paris—the forerunner of all Milk Depots—and on similar lines in Fecamp, Doctor Dufour established the first "Goutte de Lait" in 1894. Meantime in 1893 Doctor Pierre Budin founded the first "Consultation des Nourissons" in Paris, this being the original of all Infant Welfare Centers, and Schools for Mothers and Infant Consultations. These institutions were entirely new and had for their express aim the prevention of infantile mortality.

But before these were established there had long been in Paris and in other parts of France, as charitable organizations, both public and private, numerous creches, or day nurseries. Though these were not founded with the direct intention of preserving life, and though there have had to be very many modifications and developments, yet it must be recognized that the creche is the first embryo stage of what have become homes for infants and hospitals for infants.

All these efforts were put forth in the stimulating atmosphere of publicity; the history of them may be read by anyone who chooses to investigate; the effective results may be computed by statisticians. It has to be confessed that the outcome of the work was disappointing; comparatively few were the

infant lives saved, and very insignificant was the improvement in the well being of infants generally—the mothers were hardly so much as thought of. Yet in France itself, on a narrow stage, and in an obscure corner, all that Variot and Budin and Roussel and Strauss were striving to do was being actually accomplished. From 1894 to 1903 in the little commune of Villiers le Duc in central France, for ten years in succession, the infantile mortality figure was zero, there was no still birth, no mother died in childbirth, every child born during the ten years was at the end of the period "vivant at vigoureux". Will the readers of this paper have the patience to go through some of the details that brought about this wonderful result? Fortunately we have a formal report to the French Academy of Medicine by M. Pinet; the facts were considered of sufficient interest to call for special investigation, and they are absolutely authentic. The Mayor of Villiers le Duc, M. Morel de Villiers, had served in the army in his youth, and had subsequently studied medicine; he was not only the official head of the commune but was the chief personage in it—what in England would be known as the Squire. It was in the year 1884 that this Mayor attained office; he seems to have taken the greatest interest in the children of his commune and in the health of the community generally. On becoming Mayor, he took into his thoughts the health conditions of the district and amongst other things he noticed that during the years 1854 to 1863 the death rate of infants was lower than it had ever been. For 50 years there had died in their first year from 22 to 26 out of every 100 babies born in the commune. But from 1854 to 1863 there had died only 15 babies in each hundred born. M. Morel de Villiers knew that in those years his own father had been Mayor of the commune; he too had tried to do his best for the babies, and he had succeeded in saving the lives of many of them. So the son set himself to do as his father had done, and he soon found that by taking a little trouble he could do a great deal of good. In the ten years from 1884 to 1893 he brought the deaths of babies down to the same number his father had done. But the son had the additional advantage of a knowledge of medicine, and he brought all his professional learning to bear upon his work for the health of his commune. This medical knowledge enabled him to devise the most complete and thorough regulations for the welfare of the district, and then through his position as Mayor, and the large powers Mayors have in France, he was able to bring these regulations into actual operation and give them legal force. His work was complained about as doing more than he had a legal right to do, and like all those who try hard to do good, he had his detractors and grumblers. But his work speaks for itself. Under

his administration for ten years no baby died in this commune. That surely speaks for itself.

Apart from their "historical" interest—if such a term may be used in reference to so insignificant a series of events—the regulations of the Mayor of Villiers le Duc may in these days be considered as superseded, and the detailed "recommendations" which explained and supplemented the regulations are now crowded out by long and learned treatises on the upbringing of infants and the proper care for child-bearing women. But there is a beautiful simplicity and ingenuousness about all that M. Morel de Villiers writes that gives a charm. Perhaps one quotation may be allowed. "The mother's milk is the private property of the babe. Whoever deprives the babe of this, the sole right it possesses, is not only a thief but a scoundrel".

The problem of infant mortality in Villiers le Duc was solved. There were three great forces at work in absolute unison. (1) Voluntary and philanthropic force. (2) Medical skill. (3) Social and administrative authority—all concentrated in one purposeful and energetic personality. Whenever and wherever the same combination can be brought into effective operation we may reasonably expect to see the same results. But where and when will this be found? Let this be added for the encouragement of all voluntary and philanthropic workers—it was not the medical knowledge only, nor even the administrative ability added to the medical knowledge, that brought about the results in Villiers le Duc; without the keen sensibility and the true insight of a sympathetic heart the success could not have been so complete. France gave to the world the first example of milk for babies in Dr. Variot, of medical advice for babies in Dr. Budin, of homes and hospitals for babies in her numerous creches; so also in M. Morel de Villiers she showed the first example of that intimate work for babies in their homes which is best carried out by hearts inspired by sympathy and the desire to help.

All the various activities mentioned above, those hidden and obscure like that at Villiers le Duc as well as the more prominent, had thus been in actual operation in France for more than ten years before the International Congress of 1905. Under their influence the French Ligue contre la Mortalite Infantile had been formed by Doctor Roussel, Doctor Budin and Senator Paul Strauss. The example of France had naturally been extended first to its closest neighbor, Belgium. Doctor Lust established a Laiterie Maternelle in Brussels in 1897, and in 1903 the Belgian National League was formed. It is difficult to trace how far there had been in any country, except Belgium, any direct practical effect produced by the work already carried on in France. That there were indirect results is certain seeing that

as early as 1903-4 in one town of Great Britain the work of the Mayor of Villiers le Duc was known and published and in a limited form even imitated. The fact that the invitation to the Paris Congress was accepted by several Health Authorities in Great Britain, as well as by similar bodies in other countries, goes to prove that there had already been aroused a spirit of enquiry and this may be taken to indicate that some tentative efforts were already being attempted. A certain amount of attention had also been drawn to the question of Infantile Mortality by the writings of specialists, like Doctor Saleeby in England, and in reports of the Doctor, now, Sir Arthur Newsholme, Medical Officer of the Local Government Board of England and Wales, and of some few Medical Officers of the large towns. But nothing had been done in any organized form in Germany or America or Great Britain before the year 1904.

The First International Congress of 1905 thus marks a very distinct epoch. France had accumulated a considerable number of new facts, and was prepared to distribute her knowledge to all comers. She had indeed much to teach but she had also much to learn. The very name of the "Congres des Gouttes de Lait" marks the elementary and immature stage at which the Infant Welfare movement had at that time arrived. There were representatives present from almost all countries in the world, and from Paris they carried back with them to their several homes new knowledge and new inspiration. It would be an interesting study to trace the early beginnings and then to follow out the developments which followed the Paris Congress in the various nations of Europe especially in Great Britain and Germany but the subject would require large and separate investigation for each country and can only be mentioned here. Probably in every case the starting point of actual organized effort would be found to be the First International Congres des Gouttes de Lait held in Paris in October 1905. Such is the debt that the Babies of the world owe to La Belle France.

Community Nutrition Work

William R. P. Emerson, M. D.

THOSE of us who work with children realize that the health of the individual is inseparable from the health of the community, and therefore, that the prevention of disease is a community job. No achievement in recent years is of greater importance than the reduction of the rate of infant mortality, and our greatest need today is the application to older children of the principles worked out so successfully in that field.

The earliest sign of ill health in

a child appears in an impairment of his nutrition, and if this continues for a considerable period of time there results an impairment both in growth and development. The child becomes malnourished with lessened mental and physical endurance and with lessened resistance to disease. Our next step then in health work is the elimination of malnutrition among children of pre-school and school ages.

This work must be carried on with individuals; but it has become evident that the individual is best reached in groups or classes where there is opportunity for competition and mutual instruction. When mothers and children work together in these nutrition classes it is perfectly possible to see children, who come to the class underweight, undernourished and malnourished, pass in a few weeks time from a state of constant relative loss to an average gain of from 200 to 600 per cent of the normal rate of growth of healthy children of their ages, and this without change in their usual surroundings.

A careful analysis of thousands of cases during the past twelve years has shown that what these children require is attention to certain fundamental needs which we designate as the essentials of health. These are:

(1) The removal of physical defects; (2) Sufficient home control to insure good food and health habits; (3) The prevention of overfatigue; (4) Proper food at regular and sufficiently frequent intervals; (5) Fresh air by day and by night.

THE STORY OF MARIE

These essentials can only be secured by the cooperation of the four forces which safeguard the child's health, namely, the home, the school and other social agencies, medical care, and the child's own interest. The difficulties in bringing about this coordination are well illustrated by the case of a little girl who came to us through a tuberculosis association. Marie, at the age of twelve, had been found to be "pre-tubercular" and sent to a sanitorium outside the city for a number of months. She then came back home somewhat improved in health, but utterly unfit to cope with the problem which the community allowed to press upon her. A careful physical examination showed that she had no local lesions and, beyond general directions about keeping well, the medical forces offered her little help.

Fortunately, a record had been made of her weight and height and this brought her to our nutrition clinic where she was found to be fifteen per cent underweight for her height. The social examination which we give all the children in our care showed that she was not only physically retarded but was four grades below children of her age in school. This condition was recognized at school but the only way of remedying it that occurred to the principal and teacher was to put on more pressure. The teacher scolded her for neglecting her work and kept her after school.

A Nutrition Class for Fifth Grade Children

When we attempted to secure some modification in the child's program so that she might be able to have mid-morning and mid-afternoon lunches and rest periods we were told that it would not be possible to make any changes.

Naturally under these circumstances Marie did not improve in either health or school work so the authorities sentenced her to summer school in order that her deficiencies might be made up. She was released from this forced attendance only when she showed signs of a complete breakdown.

Home conditions were as bad as the other factors in this case. This most essential bulwark of defense was weak at almost every point. During all this battle with the school forces this little girl had been doing a large part of the housework for a family of eight children. She had been sleeping in a court room with another "pretubercular" child, because an older sister had to use the only fairly good room for entertaining her friends. Other buildings and the stories above cut off practically all the sunlight.

The only thing to do was to get Marie away from home for a time. She was accordingly sent to a camp where all conditions were favorable

and with full control during twenty-four hours of the day the child secured some margin of reserve power and a chance to re-establish her initiative and interest. She began to gain immediately and in a period of four weeks recovered six and three-fourths pounds of her lost weight.

In the meantime we succeeded in getting the family to move into better quarters. The mother's interest in bettering conditions was so thoroughly aroused that the home which had been an impossible place for proper living became within a few months the one which the nutrition worker regarded as the best of the twenty-five in her charge.

I wish it were possible to give this story a happy ending but after all the other walls safeguarding this girl's health had been put in good repair, the school wall proved impossible and Marie was forced back into a treadmill with all the influences a mechanical system could devise to compel a child who was really sick to do the work laid out for those who are well.

This is an excellent example of the futility of spending a part of a community's money building sanitoriums to bring children back to health, while its other expenditures for schools reduced them to a condition requiring sanitorium care. The result is that we have been obliged for the time to abandon work with these tuberculosis families living in the second most congested district in the world. Nothing but patchwork can be done with them until public opinion will compel appreciation of the fact that important as is school work, sufficient health to profit by the work is a matter of much greater importance.

THE NUTRITION INSTITUTE

One of the means which we are using the meet this community need is the nutrition institute. These have been held in a number of cities where they have served to arouse public interest among the child health organizations, the medical and school forces, and to bring into operation a definite health program. The institute is held during a period of two weeks. Six nutrition classes are started a number of weeks in advance in schools, orphan asylums and other centers to meet the special needs of the community. These classes are used for teaching and demonstration purposes.

The members of the institutes are of two types—on the one hand those who wish to do regular nutrition work as physicians, nurses, social workers, dieticians; and on the other, parents and executives of child-helping organizations, mothers' clubs and similar associations which are especially interested in their own or the communities' children.

There are usually from fifty to a hundred workers in attendance, often representing a wide range of

territory. The institutes are held regularly each spring and fall in Boston and Chicago. Others have been organized in Cleveland, Rochester, Manchester (New Hampshire), Grand Rapids, Atlanta and other cities. Beginning in September of this year a series has been planned to be held in Washington (D. C.), New Haven, Indianapolis, San Francisco and Los Angeles.

THE MALNOURISHED THIRD

The inertia of existing school administrations and other social difficulties has thus far prevented adequate progress in several of the larger cities. Cleveland is the first to give promise of an educational program which affords adequate recognition of the importance of health essentials. Grand Rapids and Rochester in their respective groups have already shown what can be accomplished when a community awakens to the problem. New Hampshire is the pioneer in planning a state-wide campaign, and New York and California have undertakings under consideration.

When one remembers that practically one-third of the children in all sections of the country are suffering from malnutrition and that this applies to all classes of society —the rich often showing worse conditions than the poor—it is evident that nothing short of a series of community programs worked out with the greatest care can succeed in bringing about marked improvement. Malnutrition is not only a condition of discomfort, distress and retarded growth, but is also a fertile soil for most of the serious illnesses of childhood and their attendant consequences.

Windows - Here And There

Sally Lucas Jean,
Director Child Health Organization of America

Windows are wonderful things. They may be the great expanse of glass in a city shop front or the yellow spaces seen at night along the village street after the shades have been drawn. I caught glimpses, as I walked abroad, through many windows, of things relating to child health and education. Many times they called up a contrasting picture here at home. Stop with me at intervals and look in at the windows.

THE FIRST WINDOW

A scene in a French school—the room is long and bare, with a concrete floor. A business-like nurse, with sleeves rolled up, stands by a long trough-like basin, equipped with faucets, scrubbing a little nine-year-old boy, who is stripped to his waist. The nurse is using a well-soaped cloth and plenty of water. You can see that the child is cheerful and shows no resent-

ment. This is done to both boys and girls who do not come up to the standards of cleanliness in a weekly examination.

THE SECOND WINDOW

Here is a primary room in one of the large city schools in America. By the door you can see that arrangements have been made for washing the hands. On the wall by the teacher's desk a large card is hanging on which a tiny picture of each child has been pasted. It is very quiet in the room and up and down the aisles one of the children goes inspecting the hands and faces of the others. They await their turns breathlessly, because they know that if any one of them is found not to be clean it will be necessary for that one to pin a little white paper pig over his, or her, own picture. As they all know and love Mrs. Richards' story of "Little Pig Brother," the act of pinning the pig over the picture is to their minds synonymous with becoming the Little Pig Brother of all the other children. You can see that every child's face is shining, and that every face on the wall is uncovered.

[Do we want our children scrubbed in school, as they do in France, or do we want them so interested in cleanliness through using the imaginative appeal of such devices as the Little Pig Brother that they will scrub themselves at home?]

THE THIRD WINDOW

Now appears the lunch room of a school in Paris. The children in black aprons are sitting at long tables, a restful expression on their faces. There doesn't seem to be any rule against talking and the children are chattering with each other in low tones. The teachers are eating with the children. The scene is a charming one, but there are many pale faces, many thin arms and legs. The lunch which is being served consists of meat soup without vegetables, boiled meat and beans. The children are eating this with chunks of bread. Each child has a bottle of wine brought from home. A hot midday lunch like this furnished by the Municipal Board of Education is available for each child in every free school in Paris, for a few pennies.

[There is no city in the United States which offers a school lunch to every child.]

THE FOURTH WINDOW

This is a lunch room in an American school. The meal, consisting of a vegetable puree, a glass of milk, two slices of real bread and butter, and apple sauce, is well-balanced and nourishing. The room, though in the basement, is full of sunlight and fresh air, and on the wall are hung bright-colored posters, and gay little health rhymes. But the children seem to have dedicated themselves body and mind to the process of eating.

There is no well-mannered conversation, no poise. One eats and one lives. That is all! These children are not learning the grace of living. In France the children's lunch at school affords an opportunity for social intercourse, and enrichment of spirit, but it does not seem to supply adequately their physical needs.

[In this country, with the assistance of nutritional experts, some of our children are getting a well-balanced meal, and much that is educational, but are they getting poise of mind and body?]

THE FIFTH WINDOW

Babies! English babies! Hundreds of them! Aren't they a delight and joy? Rosy-cheeked, barefooted, with dimpled arms and legs. Babies like these seem universal in England.

THE SIXTH WINDOW

Here is a long line of English children on the way to school. Dear me! How could the fat chubby babies these boys and girls must have been grow up to have such scrawny arms and legs? A few experts were asked whether these children were drinking milk, and they replied, "No, and we can scarcely want them to, with such an unsatisfactory milk supply." But with this same milk supply the death rate among infants is one of the lowest in the world!

THE SEVENTH WINDOW

This is a picture of a marvellously well-conducted children's tuberculosis hospital near Liverpool.

[One wonders whether it might not be advisable to spend more money in purifying the milk supply.]

THE EIGHTH WINDOW

Here we see an English girl taking a five-hour railway journey. She is armed with a children's magazine, a tennis racket, a guitar, some drawing materials, knitting, and a map which she frequently consults, drawing lines from time to time to designate the country has a box lunch which she offers to each person in the compartment. She is talking, but not self-consciously, interested in the people she is meeting and in the fact that they are visitors to England. She speaks of an abbey which is in the neighborhood of the next stop. She comments on the fact that there is nothing very remarkable about the abbey, but that the arches are of a certain period and are rather good of their kind.

THE NINTH WINDOW

The shade has been drawn at this window. Shall we leave it down? It is the picture of an American child on a railway journey.

THE TENTH WINDOW

This window is divided into two sections. In the first you see a group of English children playing happily together. The game is "London Bridge is Falling Down." The fair lady has just been captured and is in the process of choos-

ing which she would rather have, a ruby necklace or a brown pony. The children are eagerly waiting for the announcement of the choice, but there is no high-pitched excitement, or evidence of over-stimulation.

In the other section of the window, a group of American children are playing the same game. The singing is shrill and staccato and the children's motions quick and jerky. They hop up and down with excitement while the Fair Lady is making her choice, and scream with approval or disapproval when it is made. The whole performance gives an impression of tense muscles and high-strung nerves.

[If our children must live under such a stimulation and pressure, cannot we at least see that they get enough sleep and a period of quiet during the day?]

THE ELEVENTH WINDOW

In this picture you see the International Union against Tuberculosis in conference in the Institution of Civil Engineers, Great George street, Westminster, London. Some of the most prominent scientists in the field today are presenting papers of great value, but if you could hear them all, you would find no place given to methods of disseminating their knowledge, and no discussion as to how to bridge the gap between the laboratory and the laymen.

THE TWELFTH WINDOW

Here are a great many experts, all interested in some phase of health and education, talking together. Each one seems to think that teaching child health is not the responsibility of his particular department. These gentlemen from the Department of Health and the Department of Education, both recognize the necessity for action, but each is claiming that it should be taken by the other. Do we not too often find the same situation here?

The Upjohn Health Posters

Wherever efforts are being made to teach the a, b, c's of health, posters are in demand. Last year, at the annual meeting of the American Child Hygiene Association in St Louis, there were on exhibition a dozen photographs of posters, the originals of which were drawn by Miss Upjohn for the use of the Children's Bureau of the American Red Cross in their educational health work in France. So many requests came to the Association for reproductions of these posters that the Association obtained the generous permission of the Red Cross to have a number of sets made, which are now in circulation.* In this issue four of the posters are reproduced, the frontispiece being one.

In Mother and Child for Decem-

*For terms, apply to the Association, 1211 Cathedral street, Baltimore, Maryland.

See that your drinking water is pure!
Nature demands plenty of water
Offer your child a drink of water often.
Don't thwart nature!

ber, 1920, three of these posters were reproduced. One bore the legend "Wash Your Hands Before You Eat, Dirt Carries Disease;" another was on the proper food for children, and a third on adenoids. In addition to the posters which have already appeared in the magazine, either this year or last, there are in the set owned by the Association, seven others on the following:

1. The need of eating the proper food to make strong teeth, and of keeping the teeth clean. 2. "And Remember, Drink Plenty of Milk." 3 "The Common Drinking Cup Must Never Be Used." 4. The need of care of the eyes at birth, "I Must Grope My Way Through Life Because They Neglected to Treat My Eyes at Birth." 5. Fresh air. 6. Comfy clothes for children. 7. The friendship which should exist between children and fairies, and

When the doctor says the baby should be weaned see that suitable food is given at regular hours

the caution "Do Not Threaten Them With the 'Bogie Man.' Never Frighten Children."

The nurse helps old and young to keep well

The "Normal" Deterioration of Infants of the Poor as Related to Breast-Feeding

Adrien Bleyer, M. D., St. Louis

Department of Pediatrics, Washington University School of Medicine

DURING the past ten years, breast-feeding in the Infant Welfare Districts of St. Louis has become very much more common, as shown in Charts A: (1), (2), (3), (4). It was thought desirable with these figures in hand, to determine the activity of growth among the infants in a 1920 group as opposed to a 1910 group, and to discover, if possible, the relative variation from normal in the one as contrasted with the other.

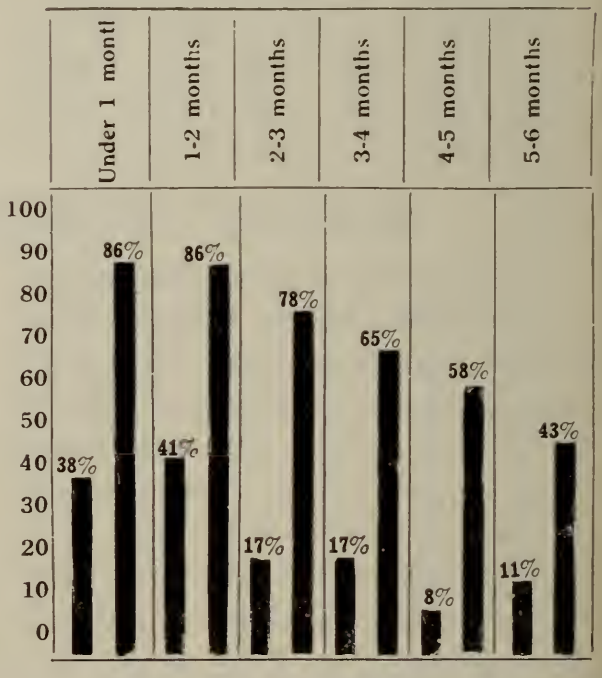
NORMAL DETERIORATION DEFINED

The infants of both groups had not yet appeared at an Infant Welfare Station, and it is the very crux of this inquiry that up to the time of weighing them, upon admission to Conference, they had been living without the guidance of persons skilled in infant care. In this way, the deterioration noted among them may be regarded as that which may be expected to occur in any similar group of infants of like age, in like surroundings, and the term "normal" may therefore be applied perhaps to a deterioration which, within rough limits, would most probably repeat itself as long as such conditions continued to prevail. It is this sense that the term "normal deterioration" is used.

No study was made to determine whether the home surroundings or other factors of unhygienic nature were in any way different in one group from those in the other, but those of us who have spent much time in the districts in which these infants live, are all agreed that the surroundings of poverty common to the crowded tenement districts of St. Louis have changed very little, if any, during the ten year period under investigation. For this reason, we feel that the variations

CHART A 1

Entirely Breast-Fed on Admission



Based on the records 1000 babies taken on the day of admission to the Infant Welfare Stations applied cnronologically.

1910 figures at the left 1920, right

Chart A 2

Entirely or in part breast-fed on admission

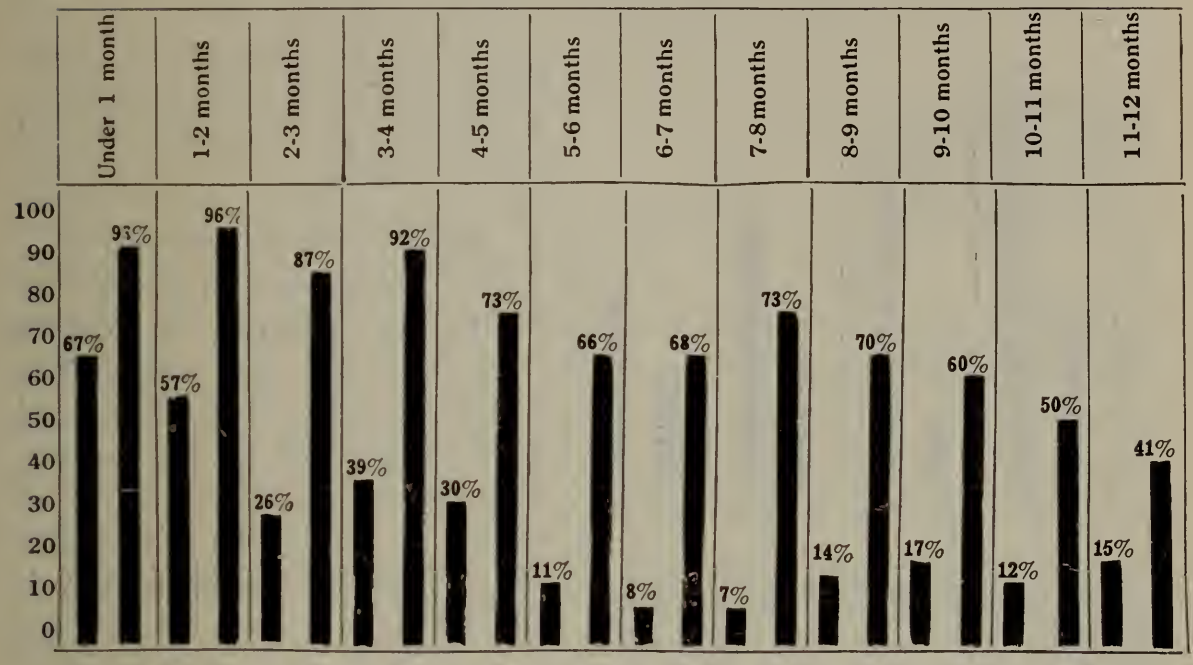
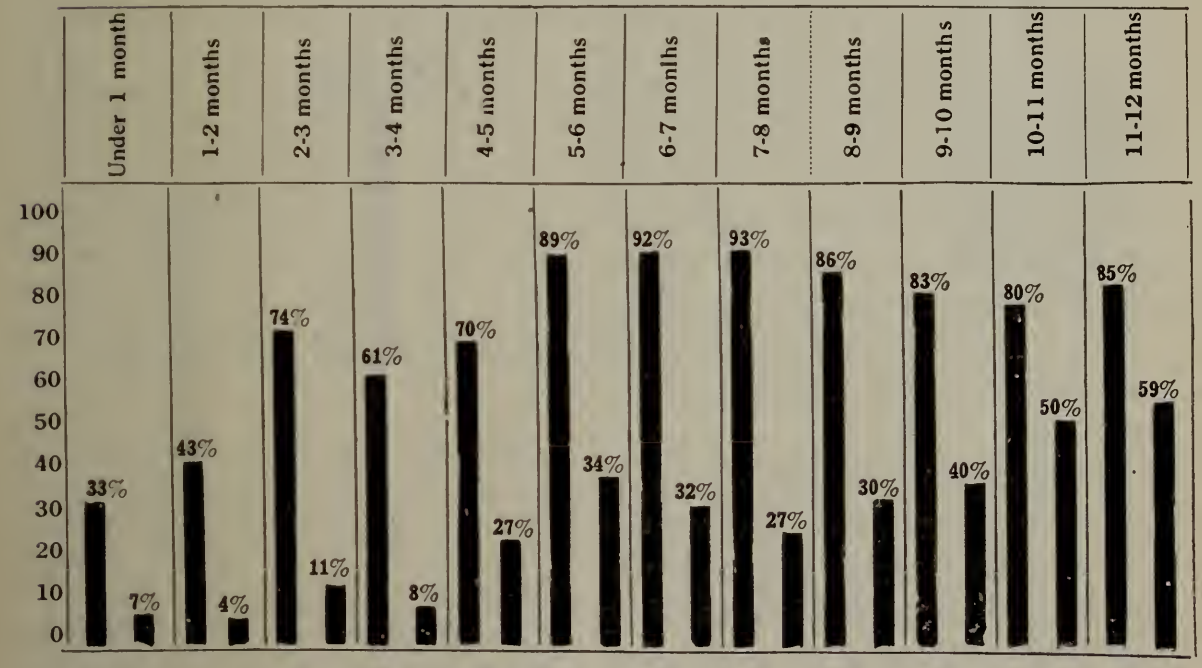


Chart A 3

Artificially fed on admission

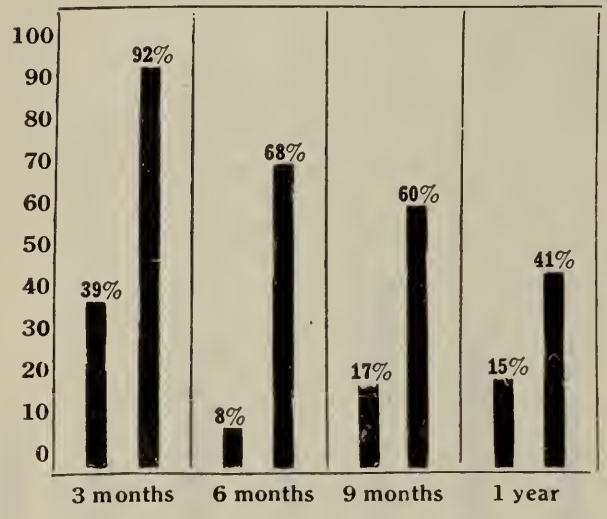


Charts (1), (2), (3), (4), *showing the prevalence of Breast-Feeding in the Infant Welfare Districts of St. Louis in* 1910 *compared with that of* 1920.
1910 *Figures at the left;* 1920, *right.*

Chart A 4

SUMMARY 1910-1920

Wholly or in part Breast-Fed



from normal which were discovered are directly related to the breast-feeding in the two groups, and in no essential degree to anything else.

In Chart B which has to do with the group of infants admitted in 1910, a deterioration is noted at the very start, that is, among those admitted during the first month of life 67 per cent of whom were breast-fed; whereas in Chart C, which has to do with the infants admitted to the Stations in 1920, with 93 per cent wholly, or in part breast-fed, no deterioration whatever is found to have occurred during the first month.

At the third month the deterioration in the 1910 group had reached 20 per cent corresponding to a proportion of breast-fed infants of 39 per cent, which may be compared to a deterioration of only 1 per cent at this age in the 1920 group among infants in whom 92 per cent were breast-fed.

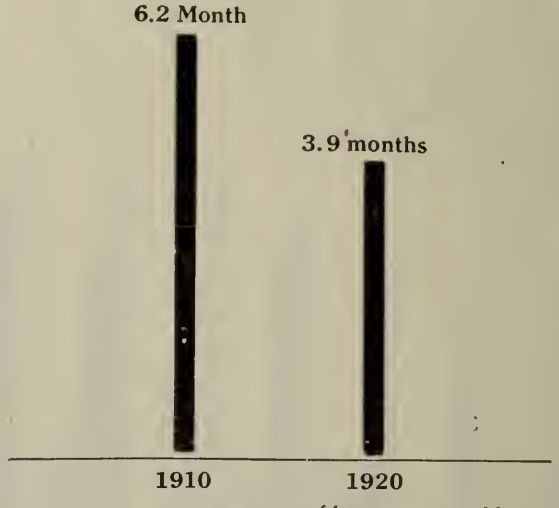
Comparison of Chart B with Chart C shows the variation in growth in 1910, the period of low breast-feeding, and the variation in growth in 1920, the period of high breast-feeding.

DETERIORATION PROGRESSIVE

The deterioration in both groups is progressive, that is, the older the child, the greater the variation from normal, a fact which was much more pronounced, as may be seen, in the former group than in the latter. In the 1910 group this amounted to no less than 24 per cent at six months, and at nine months, had

CHART D

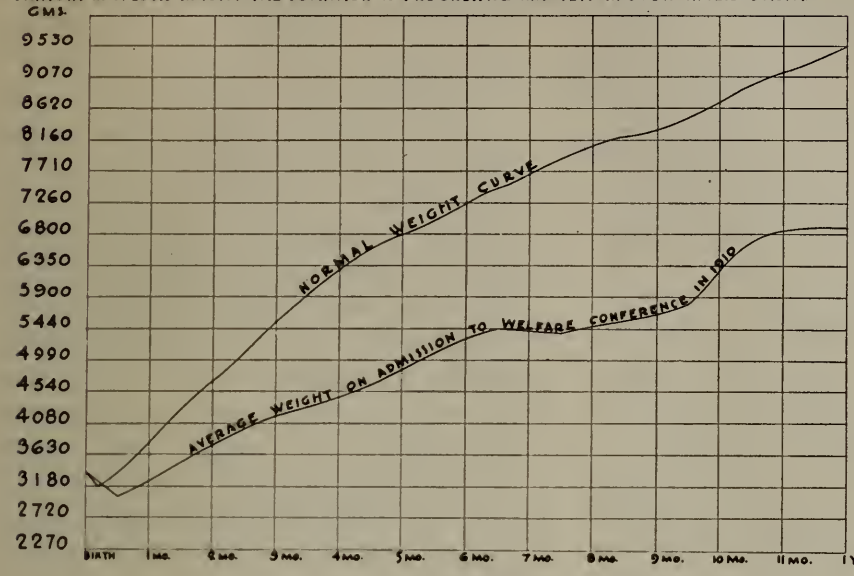
Average age on admission to conference of infants under one year in St. Louis in 1910 and 1920.



As seen in Charts "B" and "C" deterioration is coincident with delay in reaching the welfare stations. The value of the reduction in the average age of admission becomes apparent.

CHART "B"

AVERAGE PHYSICAL DETERIORATION OF A GROUP OF INFANTS PRECEEDING ADMISSION TO THE WELFARE STATIONS IN ST. LOUIS IN 1910. THE DEVIATION IS PROGRESSIVE AND SETS IN SOON AFTER BIRTH.



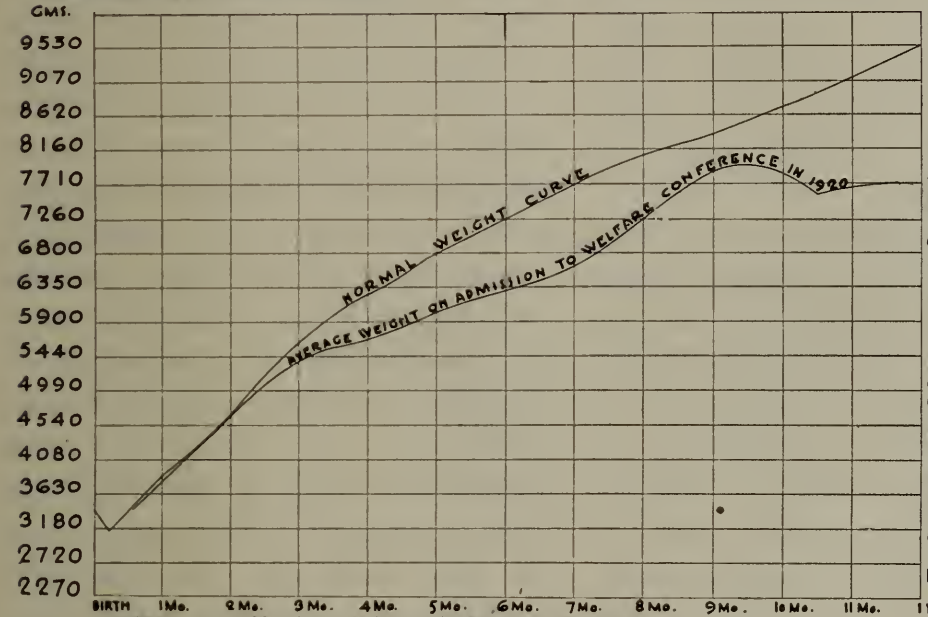
DEVIATION AT 3 MONTHS - 20%
" " 6 " 24%
" " 9 " 30%
" " 1 YEAR 27%

BASED UPON THE RECORDS OF 500 BABIES COMPILED CHRONOLOGICALLY, SHOWING THEIR AVERAGE WEIGHT ON ADMISSION TO THE WELFARE STATIONS, AT THE CHILDRENS' HOSPITAL, & THE LABORATORIES OF THE MILK COMMISSION IN 1910.

SEE CHART SHOWING PREVALENCE OF BREAST-FEEDING AMONG THE POOR IN ST. LOUIS IN 1910.

CHART "C"

AVERAGE PHYSICAL DETERIORATION OF A GROUP OF INFANTS PRECEEDING ADMISSION TO THE WELFARE STATIONS IN ST. LOUIS IN 1920.



DEVIATION AT 3 MONTHS - 1%
" " 6 " -10%
" " 9 " - 7%
" " 1 YEAR - 18%

IN 1920 THE DEVIATION IS PRACTICALLY NIL THROUGH THE FIRST 3 MONTHS; IS LESS THAN HALF THAT OF 1910 AT 6 MONTHS; ONE FOURTH THAT OF 1910 AT 9 MONTHS; AND TWO THIRDS THAT OF 1910 AT 1 YEAR.

BASED UPON THE RECORDS OF 500 BABIES COMPILED CHRONOLOGICALLY, SHOWING THEIR AVERAGE WEIGHT ON ADMISSION TO THE WELFARE STATIONS. AN APPROXIMATELY EQUAL NUMBER OF RECORDS WERE TAKEN FROM EACH OF FIVE STATIONS SITUATED IN DIFFERENT PARTS OF THE CITY IN 1920

COMPARE TO CHART SIMILARLY CONSTRUCTED FOR 1910.

reached 30 per cent, whereas in 1920, the figures were respectively 10 per cent and 7 per cent for these ages.

In like manner the rate of deterioration is clearly related not alone to the age of the child, but to the time which has elapsed before admission to an infant Welfare Station. The older the child before admission, the greater his variation from normal weight.

Chart D represents the average age upon admission in the two groups, and shows that progress along this line had also been made.

This is of course, desirable, but it is not a fundamental need. By seeing babies early in life, we are of course able to prevent a great deal of discomfort and unhappiness in home life due to improper feeding at the breast, but such things are secondary in importance to an available supply.

CONCLUSIONS

From the foregoing, three conclusions may be drawn.

1. The growth in weight of young infants may vary but little from normal standards in the face of many unsanitary factors such as overcrowding, poor ventilation, over-clothing, uncleanliness, and so forth, provided an adequate supply of breast milk is available. This is therefore the factor upon which the efficiency of home care most largely depends.

2. The essential need of the young infant then being breast milk, provision should be made for securing and maintaining an adequate supply of this by means of instruction and supervision by nurses familiar with the methods best adapted to this end, who will reach the mother as soon as practicable after the birth of the baby, and who will direct her care of the baby until he is brought to an Infant Welfare Station for examination by the physician, and directions, if any are needed. The Infant Welfare Station does not in itself supply the need of the young infant, and is not highly essential to his care during the early months of life. This period belongs to the nurse.

(These conclusions, it should be stated, coincide exactly with those of Doctor Sedgwick and Doctor Huenekins of Minneapolis, where much attention has been paid to this particular phase of Infant Welfare work. It was interesting to note that on the chart sent by Minneapolis for exhibition at the Meeting of the American Child Hygiene Association in St. Louis last October, that over half the home visits made by the nurses in that city were what they called "breast-feeding visits", and that the Infant Welfare Stations were classified under the needs of the second year.)

3. Lastly it may be stated here that mortality records alone no longer afford a satisfactory basis for determining the efficiency of the work done by an Infant Welfare Station in a given community. Such efficiency may be judged more precisely, perhaps, by a tabulation made from time to time of the weights of infants, say of groups of five hundred or a thousand infants, selected chronologically upon admission to service and for comparison after a given period. Such a study will be sure to show at what particular age the least satisfactory as well as the most satisfactory progress is being made by the work of the Station and would be a good guide for new Stations, if made every year or two until their relation to the community had become established. When systematized, it is surprising how easily such tabulations, even of large groups, can be made.

"The Play's the Thing"

Margaret Steel Moss

Social Worker, Child Health Division Pennsylvania Health Department

No, this isn't a place where children of three acquire a complete knowledge of Sanscrit by the 'natural' method, nor is it a place where excess baggage females wearing a veil and a smile penetrate the mysteries of rhythmic expression and coordination. It is something more remarkable. It is the spectacle of some two hundred grown-ups sitting under a tent, ten hours a day, on hard undertaker's chairs and being thrilled by a presentation of the job in which they all have a part.

Such was the unique record of the four-day Camp of Instruction conducted last August, at Mont Alto by the Pennsylvania Department of Health.

At the 'military invitation' of Commissioner Edward Martin, each Division Chief had been turned into a playwright and while for some this unaccustomed task proved rather fearsome, when the time came the dramas were produced and these people whose business is not usually writing plays turned out some remarkably good results, for they caught the dramatic elements that exist in every human relationship, and that was what they presented.

"When it came to the acting, those who filled the roles in real life took corresponding parts in the plays. In this way the technique of each Division's demonstration was exact. But they did not stop with that. They portrayed unofficial people too—every-day people —the ones for whom the Department exists.

All the varieties were there—those who hinder and those who help—Mrs. McCreary who wanted the Health Officer to postpone quarantining her house until after she had been to the church supper, the farmer who needed to be shown the dollars and cents advantage of a better milk service, the School Board President who became converted to the Department's program and the Mayor who decided to join the winning team. And each of these people became a part of the big graphic lesson of a Health Department in action.

One of the most remarkable achievements, however, was the way one group put the 'vital' into 'vital statistics.' A Division usutlly conceived as being a matter of mere cubic feet of files became a very human affair when Mrs. Becky Stein tried to get working papers for her thirteen year old son and when Mrs. Rastus Brown found that she could not collect her husband's War Risk Insurance with-

out the information that should have been registered years before at this office, and was then shown how, lacking the official record, the legal evidence could be provided.

Perhaps it was a Senator from Wisconsin calling on the Head of the Division of Accounts, or a distinguished English guest interested in the program of the Tuberculosis Division, or an irate farmer concerned with the funeral arrangements of a neighbor's horse,—a very dead horse apparently. But in each case the activities of the Department were unfailingly portrayed in their relation to the citizens of the Commonwealth—and the scholars at this school learned another lesson.

In appreciation of the essential part the local people must play if the health program, that is so much bigger than the Department, is to be realized, a session was devoted to the organization work in an unnamed town—one of those unique communities that is 'different from any other place.'

After the chief obstacles had been overcome a meeting was held of the committee, composed of Mrs. Rush and Mrs. Delay, Mrs. Lovechild, Mrs. Goodsort, Mrs. Well-meaning and Miss Gloom. They were all there,—inevitably there. But they got the Child Health Center going. The opening of the Center was demonstrated at another session and it came to Mrs. Youngmother, Mrs. Secondsummer, Mrs. Helpless, Mrs. Toddler, with her string of three little runabouts, and the rest, all seeking for their babies the start in life that means a better race of citizens in the future.

No doubt there are technical manuals telling how a Health Center should be run: Appendix A, showing a diagram of the room; Appendix B, giving a price list of equipment; Appendix C, devoted to a height and weight chart for children; and perhaps Appendix D, illustrating the latest styles in infant toggery. But there is no mention in these books of the long cucumber from which one baby must be rescued, of the new volunteer's flutter of stage-fright, of the problems that are more than health for which the help of other agencies must be sought, of the quiver of excitement as the scales are balanced, of the general rejoicing when the report is good, and the doctor's strengthening words of advice when it is not. Yet these are all part of a Health Center—pamphlets with appendicitis notwithstanding. The strongest proof that these points were not overlooked in the demonstration was the comment of a small boy who happened to be in the audience. 'That reminds me of home,' he said. 'It is just like the place my mother used to take me when I was little.' And indeed a similar tribute might have been paid to all the presentations.

A refreshing addition to the Conference program was the presence of Miss Violet Williams of the National Playground Association,

who is now developing the play idea in York, Pennsylvania. During some of the occasional three minute intermissions she led the class in some extraordinary calisthenics. But the climax came on the last evening when more plastic pupils, —a group of the children from the Sanatorium,—came out on the lawn, and under her direction gave a demonstration that transported the spectators back to the Forest of Arden. It was just the touch of color and charm that every conference needs.

When the Camp broke up the pupils in this new kind of school became once more doctors, nurses, county chairwomen, Red Cross representatives, and health officers. North, South, East and West they scattered, carrying a new appreciation of their job and a new conception of way to pass along their message of health and happiness.

Points In a Community Survey

Margaret Curtis, Boston

Miss Margaret Curtis is the author of a Brochure in the Child Health Series published by the Medical Bureau of the American Red Cross in Paris. Miss Curtis here presents the following points to be covered by a community survey, which, she says, is necessary in the medical social service now going forward under the Red Cross in Europe. She says that the points are suggested with no idea that they are exhaustive, but as showing a workable program.

It is of the first importance that any worker making a survey should have proper letters of introduction, not only to officials, but to heads of private societies as well. This will save time, help to get results and avoid serious future complications.

Physical Conditions of the Community:
1. Water supply. 2. Housing. 3. Sewerage. 4. Transportation system. 5. Condition of Streets.

Industries:
1. Prevailing industries. 2. Men's wages and hours of work. 3. Women's wages and hours of work. 4. Child Labor.

Schools:
1. Suitability of buildings. 2. Overcrowding. 3. Race distinction.

Health:
1. Organization of health department, city and state. 2. Birth rate. 3. Death rate. 4. Causes of death. 5. Infant mortality. 6. Tuberculosis. 7. Contagious diseases. 8. Illegitimacy. 9. Number of doctors and nurses.

Public Health Activities:
1. Hospitals. 2. Dispensaries. 3. Anti-Tuberculosis work. 4. Anti-V. D. work. 5. School inspection. 6. Well baby clinics. 7. Milk supply.

Care of Dependents:
1. Local public care of the poor, including widows, pensions and other allowances. 2. Local public care of children. 3. State care of children and widows. 4. Private organizations for the care of the poor. 5. Private organizations for care of children.

Institutions:
1. Almshouses. 2. Homes for the aged. 3. Orphanages. 4. Day Nurseries.

"A survey should contain a list of the people seen and their attitude towards

the suggested program, their criticisms, objections and their own propositions. Care should be taken to get the attitude of the community outside of the people closely allied to public health work. Naturally the understanding and support of the medical and nursing profession is particularly important. These must be won."

In the same brochure Miss Curtis says: The Serbian Child Welfare Association of America has organized clinics and is giving treatment, about which they make the following report:

> 'There is a new system in vogue in the Okrug with reference to educational work which we expect to make universal for all the work we do in Serbia. It is that of making a class out of every clinic. In other words, any patient reporting to the dispensary for any treatment whatsoever is given individual talks on whatever pertains to his particular case. For example, if he has an infected finger, the waiting patients in the dispensary are given a short talk on this particular case. Why he has an infected finger, how it should be taken care of, and so forth, laying special emphasis on health and hygiene in general. This system should act as a preliminary to the heavy education work of lectures which will be given later on.'

Another interesting statement in the same report is as follows:

> 'The Serbian class with which we deal is not converted to reconstruction. They have been fed on relief for so long a time that it will be necessary to use considerable publicity and propaganda to convert the populace to the idea that it is health and hygiene and sanitation that they need and not relief measures.'

And finally the Serbian report brings out the fact that they have found the school teachers in most communities more advanced along these lines than the public officials or others in the community and, therefore, that it is wise to always include a teacher on the local committee.

Nutrition Classes for the Nurses in Philadelphia

Through the courtesy of the Child Federation of Philadelphia, Miss Anna L. DePlanter, of Pratt Institute and Teachers' College, will give a course of instruction on nutrition, covering a period of five months this fall, to all the nurses of the Bureau of Health, the Board of Public Education and the Visiting Nurse Society.

A more intimate knowledge of nutrition problems by city nurses and school nurses will enable them to conduct intelligently and scientifically nutrition classes in the Health Centres and Schools among the poorly nourished children of pre-school and school age.

The outline of these lectures as printed below indicates that nutrition plays an important part in our program of preventive medicine, especially that which applies to children.

Outline of Course in Nutrition

I. General Nutrition
- (a) Nutrition vs. Dietetics
  - Nutrition Experimentation — Animal Experimentation
- (b) Balanced Diet
  1. Energy
     - Sources of — Relative value and costs
  2. Building and Repair
     - Sources of Protein and Ash — Relative value
  3. Regulatory Foods
     - Importance of Ash constituents
     - Sources of Calcium, Phosphorus and Iron
     - Specific functions of each
  4. Vitamines
     - History — Kinds
     - Sources — Function of each kind
  5. Daily Requirement of Protein and Ash

II. Basal Metabolism and Energy Requirements
- (a) Respiration Calorimenter (b) Conditions affecting basal metabolism
- (c) Conditions affecting energy requirement
- (d) Table of energy requirements for various occupations
  - (Each student compute her own daily requirement)
- (e) Energy requirement for Children

III. Food Requirements of Prospective Mother

IV. Food Requirements of Nursing Mother

V. Food Requirements of Infants
- Breast vs. Bottle Feeding

VI. Food Requirements of Child
- 9-12 months — 2-3 years
- 12-18 months — 3-7 years

VII. Food Requirements of the School Child 7-10 Years

VIII. Food Requirements for Adolescent Boys and Girls

IX. Food Requirements from 17 to 25 Years
- Dietaries and menus were carefully worked out for each of these periods

X. The Food Budget
- (a) Market orders for 1 week for a family of five
- (b) Proper division of money for foods necessary to health with special emphasis on food for children

XI. Nutrition and Malnutrition
- (a) National health problems
- (b) Survey of literature on Malnutrition
- (c) Malnutrition a community problem
- (d) Standards
- (e) Causes of Malnutrition
  1. Physical defects and diseases
  2. Poor diet
  3. Poor eating habits
  4. Fatigue
  5. Poor posture
- (f) Types of Nutrition Classes

XII. Food Habits of Racial Groups
- (a) Jewish (b) Italian (c) Polish
- (d) Native dietary habits and food tendencies of each group in adapting itself to American living
- (e) Dietary deficiencies of each group
- (f) Main points in psychological approach to each group

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A Magazine Concerned With Their Health

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NOVEMBER, 1921

A Health Demonstration

Six large national organizations, with programs born of complex modern conditions of life, a year ago formed a coordinating council. Its purpose was to see how a correlation of present-day health and welfare plans might help most to secure for the communities of this country, among other things, the kind of complete, effective service so ably given his fellow-citizens by Morel, of Villiers le Duc, as told in the interesting article by Mr. Benjamin Broadbent, elsewhere in this number, describing what the babies of the world owe to France.

A year is too soon for a test of any important movement, particularly one dealing with such a many-sided problem as the adjustment of varying national programs for the health of children. However, certain interesting lines of policy and even definite results of the Council's efforts now challenge attention.

Observers of its work have been impressed with the careful and thoughtful way in which it is attempting to work out its policies so that each step may be a forward one.

In the matter of adjusting standards and ideals the Council has tried to avoid the pitfalls of the past, into which many have fallen because of compromise just for the sake of avoiding an issue, or else because of a purely laissez faire policy. National advisory committees have been organized which are broadly representative of government departments, leading national groups and societies, and especially able individuals in their respective fields. These committees are beginning to prepare authoritative statements as to policies and programs which have been proven sound in dealing with important problems of child health, upon which more light is needed.

The work of these committees is largely in the formative stages, but gives hope of widely useful results. They are recognized as authoritative, their decisions so far have been reached in the spirit of good will and accord, and they are already beginning to work out fundamental principles upon which to base a practical program for the health of school children and other phases of work for children.

In Mansfield and Richland County, Ohio, under the guidance

of Dr. Walter H. Brown, formerly health officer of Bridgeport, Connecticut, the Council is beginning a cooperative effort to assist a community to bring together its own forces for promoting the health and happiness of mothers and children (as part of the entire community health program), in a way that will most notably contribute to a sound citizenship. No predetermined plan for this demonstration has been laid down. The thought of the Council is rather to use the best experience available, merely as an aid in developing a comprehensive and balanced scheme that shall be of most benefit not only to Mansfield and Richland county, but to the entire country.

Balzac's Ideal Realized

When Balzac wrote his novel "The Country Doctor," he pictured an ideal mayor-physician of France who devoted his life to restoring a French village which had been desolated by bad hygiene and industrial apathy. He constructed for literary purposes a character which he was perhaps not too hopeful of material realization in his own day, especially, since he was ultimately disappointed in the lack of warmth with which his novel was received by the public. Nevertheless, Balzac's ideal came to life. It can scarcely be doubted that M. Morel, Mayor of Villiers le Duc, was influenced by Balzac's novel more than he himself realized, when he began the first modern campaign ever instituted for saving babies' lives in his village. We have been talking in modern days of the need of demonstration centers for child health, as the logical development of the activities of Child Welfare work since the first international congress in Paris held in 1905. But to realize that even before that Congress had met a genius had already put in operation a baby-saving center in an obscure French village, brings again to our notice the fact that sometimes the first attempts at anything are surprisingly good. It requires genius to discover the new thing; to improve or imitate is possible of accomplishment without this divine fire, but genius sails all alone into the uncharted seas of knowledge.

Homer's poetry, Soranus' nursing care, Hippocrates' medicine, and Phidias' sculpture are still supreme works, although they were the first of their respective schools of knowledge. And Morel's health center in a French village still commands our admiration—and our astonishment.

Benjamin Broadbent, the venerable ex-mayor of Huddersfield, a pioneer in England in the work begun by Morel in France, writes in this issue a fascinating historical sketch of the work of the French physician-mayor. No one should fail to read this story of the achievements of one great man, told in the language of another.

The Day's Work

"I CAN AND I WILL"

The slogan, "I can and I will," is posted on the walls of each classroom in the school for crippled children which has been opened this fall for its second term at No. 5 School, Rochester, N. Y.

The 38 children now in attendance could not go to school if their transportation to and from the building had not been undertaken by the Rochester Guild for Crippled Children. In a large number of cases pronounced physical defects are being corrected in an encouraging degree. Visitors remark on the cheerful atmosphere that prevails, and the mental alertness of the children. (*Rochester Democrat, September* 12, 1921.)

DETROIT'S NURSERY SCHOOL

An experimental nursery school is soon to be established in Detroit, Michigan, by the Merrill Palmer School, in cooperation with the board of education. Girls selected from the public schools will be trained in the care of children of pre-school age, taken from homes where there are no mothers to look after them. (*Detroit News, September* 10, 1921.)

"HEALTH FIRST" BUTTONS

Systematic medical examinations are made of the pupils of the public schools of Baltimore and other Maryland cities by the Public Athletic League, as far as the funds at its disposal will allow. If the examination fails to reveal any remediable defects, the child is awarded a "Health First" button, signifying that he is in good physical condition. In addition, a letter of commendation is sent to the child's parents complimenting them on their care and interest regarding the child's health. If the physician does discover one or more remediable defects the parents are notified and urged to have them remedied. After a brief period the visiting nurse visits the home of the child to learn if the defect has been attended to; and if not, to help make arrangements to have this work done.

The annual report of the medical department of the league for the school year 1919-20 shows that 12,504 children were examined by physicians of the league. Of this number 8,510 were boys and 3,994 were girls. Twenty-eight per cent of the boys were awarded the "health first" button while only 12 per cent of the girls received a similar award. (*School Life, September,* 1921.)

CHILDREN'S BREAKFASTS

Does your child go to school ready for a good day's work? That is, has he had what will stay by him for the morning or has he had merely a stimulant for his nerves? One school in Newark, N. J., in or-

der to demonstrate how the condition of undernourished children can be improved, has chosen forty children to be under observation while receiving proper nutrition. The children are divided into two groups according to physical defects, and each group has a meeting with the parents and teachers once a week after school. The children are weighed at alternate meetings and there is discussion of the rate at which they gain, and reasons for difference in various cases. Health principles are spread through the community by these meetings. Many of the parents are willing to improve the children's diet when the demonstrations make them realize what is wrong. In a preliminary survey of the families of the children selected as most in need of nourishment it was found that in every one of the forty cases the child came to school after a breakfast consisting of coffee and roll, coffee and sweet cake or simply coffee.

Instructors and food for the class are provided by the extension service of the New Jersey State College and the New Jersey Tuberculosis League. (*School Life, September*, 1921.)

FREE PRENATAL CARE

Prenatal care administered free of charge by the Department of Public Health of Philadelphia is reducing the infant mortality rate according to statistics announced by Dr. C. Lincoln Furbush, Director of Public Health. In 1920, of the 2,881 infants born under the care of the department's division of Child Hygiene, 68 died when less than one month old, constituting a death rate of 24 per thousand. Comparison with similar data for the entire city shows that 1,527 babies died during the first month of life out of 43,547 born alive, making a death rate of 35 per thousand. Thus the rate of death among babies whose mothers have received such prenatal care is one third less than the general rate of infant mortality for the city. (*Journal of the American Medical Association, September* 10, 1921.)

A PRIVATE NURSE'S SUCCESS IN KEEPING BABIES ON THE BREAST

Miss Mathilda Carlson, a nurse formerly on the staff of the Breast Feeding Investigation Bureau of the Department of Pediatrics of the University of Minnesota, has written an article describing the results which have followed her work as the nurse engaged by an obstetrician in his private practice. Miss Carlson says, in speaking of the infant welfare workers, that "they are not able to come in direct contact with the mothers as early as is desirable for the best results." She says that "there is a group of people, often referred to as the 'upper, or well-to-do class' who do not, as yet, take kindly to visits or suggestions from welfare or social service workers. Physicians and nurses who do come in contact with this group find children who are under

weight and who show malnutrition both in infancy and in early childhood. During the past year and a half I have come in contact with many mothers and children of this group. * * *. I see them and their babies shortly after the child is born to give such instructions as may be needed and then see the babies at regular intervals or whenever necessary throughout their infancy.

"So successfully has this plan worked that every infant supervised in this manner has been breast fed from 4 to 10 months. Out of 72 cases seen only two needed additional food from birth; both of these were partly breast fed five and eight months, respectively. Five more were given additional food during the third, fourth and fifth months. For four months 100 per cent were at the breast, and 88.5 per cent were entirely breast fed six months. At this time we usually begin to add gruels, or well cooked cereals, and if the child is well nourished and up in weight we omit the fifth or 10 P. M. feeding, as a healthy, normal child usually sleeps all night. * * *

"After observing a number of babies closely the first month or two, I have come to the conclusion that it is better to be satisfied with a small gain at the breast rather than to begin additional food too early. Sometimes an infant whose weight may remain almost stationary three, four and even up to six weeks, taking 15 to 18 ounces of milk in 24 hours, will, a little later, gain 25 or 30 grams a day on practically the same amount of food. These mothers, then, realizing that it was the baby rather than the food that was at fault, become our best distributors of breast feeding propaganda, while if artificial food had been added, the breast feeding would have become secondary, and the baby weaned sooner than otherwise.

"Maternal feeding need not be a burden to the young mother, and after lactation has become established, it is not necessary for the mother to be always at hand when the clock strikes the hour. By teaching her expressing, the mother may empty her breasts and save the milk, if social or other engagements interfere with the feeding hour. For an evening affair, the six to ten period may be lengthened to eleven or twelve, or whenever the mother comes home, as oftentimes the baby will sleep past the last hour of the day.

"When a mother has learned to appreciate the value of breast milk she hesitates to wean the baby entirely and I have known several instances of the mothers keeping the early morning breast feeding for several weeks after the baby has supposedly been weaned, to ward off "teething" and "second summer" ills, knowing that the breast milk can be brought back if necessary.

"Of the babies so supervised, approximately 44 per cent are past

their first birthday and they have been remarkably well and free from intestinal disturbances, and there has been only one death—(erysipelas following adenitis and suppurating otitis media.) * * *

"Every mother is anxious for her baby's welfare and she can easily be made to see that what nature has provided is by far best for its normal growth and development, and even though her supply of breast milk may be insufficient, 'half a loaf is better than none.'"—*Archives of Pediatrics, Vol.* 38; 9.

SCHOOL ABSENCES FEWER

Children of school age in Philadelphia who are kept away from school by physical or mental defects numbered 1,255 during the year 1920-21. The figure has been reduced to 800 this year, and further reduction is expected. (*Philadelphia Evening Ledger, September* 16, 1921.)

SCHOOL DENTAL CLINICS

In School Life for September, 1921, the results of an investigation made by the Bureau of Education show that 286 cities in the United States have established dental clinics in connection with their public school systems. In 181 instances these clinics receive support from the city boards of education; in 33 from the city health departments; in 22 from health departments and boards of education jointly; and in 50 from the Red Cross or from private donations. Massachusetts outranks all other states with respect to the number of cities maintaining such clinics, laying claim to 34 of the total of 286. New York state follows with 23, New Jersey with 21, and Illinois with 17.

A FLYING DOCTOR

The way in which one field worker successfully approached the irreducible minimum of "being in two places at once" is told by Dr. Ada E. Schweitzer in a letter to Doctor Foote. "On Friday evening I discovered that I had two engagements on Monday in places about 250 miles apart with no good train connections. I had scheduled the Division for La Grange County School for the week. The staff was to arrive on Monday to arrange rooms for a Child Health Conference while I was to go to Sullivan for a lecture to a Parent-Teachers' Club and Farmers' Federation that night. In the meantime, La Grange had scheduled children from three townships for Monday, so I appealed to Major Rich for an aeroplane.

"After examining children up to three o'clock I left La Grange on Monday in a Curtiss Oriole sent from the Station at Kokomo, with Pilot Jacoby. After stopping at Kokomo for gas we arrived in Sullivan in time for my lecture. This morning (Tuesday) we got back to La Grange about 11:15; I was met by an auto, and driven immediately to the Court House to go on with the examination of chil-

dren. Other doctors had done the work while I was gone.

"As it was my first trip, I found it quite exciting. Part of the time we were above the clouds. I took some pictures of the little farms and houses along the way. The fields looked like the squares on a checker board except that the colors were more varied. I am wishing now that I might have an aeroplane for my personal use. It furnishes delightful rapid transit."

SEGREGATING THE SUBNORMALS

Complete physical and psychological tests are given every child who enters Public School 64, Manhattan, New York City. Based on the result of these tests the child is assigned tentatively to one of the eight types of classes which have been organized in that school. His rate of progress through the school course will then be planned so that the gifted child will finish the regular eight year course in six years, the bright in 7, the average in 8 or 9, the dull normal in 10, and the defective in whatever time he can.

The unusually bright children are not rushed through the course but are offered a curriculum enriched with such subjects as French, art, dancing, music and craft work. A special curriculum is also being developed for children who are not mentally defective but who are definitely backward. These children, who are generally over age and have little interest in school work, are appealed to by concrete experience, with less use of books than would be required of any ordinary class. Pupils so far below the average as to be suspected of mental deficiency are placed in observation ungraded classes for special care, medical attention and individual teaching. Some of these children return to the regular grades after a term or two under observation, while others prove to be really defective mentally and they continue in the special class.

Besides classification on a mental basis, there is provision for children who are physically or emotionally in need of treatment. A neurotic class receives children who are temperamentally peculiar, abnormal in some way but not necessarily mentally defective. A nutrition class cares for children who are underweight and need special physical attention. Health is the center of the curriculum of this class. Home cooperation being necessary in this work, visits are made to the pupil's homes, and mothers' classes meet at the school.

Return to the normal class is always a possibility, for the school aims at perfect flexibility and interrelation of groups. The original grouping is used as a starting point and working basis. Changes are made on the recommendation of teachers and as the result of observation, but these changes, though important for the individual child, do not affect the original grouping much, for they amount to less than five per cent of the whole.

MISS LEETE'S CALIFORNIA NOTES

It has been the privilege of the Field Director of the American Child Hygiene Association to visit many Directors of Bureaus of Child Hygiene, and each time, as the work has been explained, one truth has been outstanding, namely, that each state has its own peculiar problem. However, a memorable experience on a visit to the California Bureau of Child Hygiene seems of sufficient interest, aside from any technical phase of the work, to warrant a brief report.

A trip with the Director and her staff to one of the northern counties, which in itself is as large as are the States of Rhode Island and Delaware, was of such keen interest, I am sure some of the eastern Directors would appreciate knowing the western problems. The trip was taken in a well-known machine, which refused to carry Dr. Waters and her staff to their destination, and it is to be hoped that the new car, which awaited the Doctor upon her return from this particular 952 mile trip, will carry her safely even though the experiences may not be quite so unique. What did happen? Merely this: Four women, with all of their belongings packed compactly either in the car or tied securely to the outside, left San Francisco in the early morning of September 16th, and by dint of the persevering efforts of Dr. Waters and her assistant, Miss Clary, who alternated with the driving, we reached our first stop at 10 o'clock. We easily found the hotel designated, for the first proprietor asked, said there were only two hotels in the place who took "white folks", and as the nurse had not planned for us to stay with him, she must have intended for us to go to the other place.

A downpour of unexpected rain on the following morning, did not prevent the mothers of the community, some of them from far back in the country, from arriving at the conference room. All day the Doctor carefully examined each child, and with a smile gave a bit of inspiration to each anxious mother, until when five o'clock came, one began to appreciate what it must mean to smile 93 individual personal smiles and to give something of value to each waiting mother.

To be sure, the community nurse and the women who had given of their time to prepare for the conference were there to help in every way possible, even to the serving of luncheon and dinner to the staff, and perhaps most of all, by expressing their interest in the conference itself. However, the day did not end at five, or six, for the evening called for talks on "Health" at the local theater.

The following morning found us ready for the next step, and men who had been over the road assured the Doctor that "perhaps" she could get through, so off this car started with its optimistic personnel. Did we enjoy the ride? Yes, for "we walked and we rode."

On the map California may look rather straight, but riding north, the road must have been quadrupled, for it is all curves, and to those of us who walked in the slipping road, where one seemed to take one step ahead and slide back two, the road seemed to be all upgrade—and we did make two 30 per cent grades. But withal the scenery was so marvelously beautiful, no one minded the slipping, sliding walk with the rain quietly pouring down until every one was soaked. To stop meant not reaching our destination and it proved fortunate that edibles had been tucked in before leaving Fort Bragg; otherwise, we would not even have had crackers for our dinner.

We did stop when two little pigs persisted in running in front of the car and started around the steep, narrow cliff road, for they would not turn away until they were driven back.

We were repaid for one of our longest walks, for had the machine not been quietly waiting for us, the lovely deer would not have stopped in the middle of our path and inquiringly inspected us.

Having been told of a place which would house us for the night, we went bravely on in the gathering twilight, until the dusk changed to darkness, and not a sign of a neighborly light. The soft, sticky mud allowed the wheels to go deeper and deeper, until suddenly not another inch would the little car move—even the flash-light failed to throw its little gleam. There was not a thing to do but wait for the first rays of morning light—even though the bright eyes of a wild cat peered through the bushes, but disappeared when the bright eyes of the machine were turned on.

All night we sat in the little machine—I might say we shivered and sat—for rain-soaked clothing is not conducive to comfort — neither would I select a suitcase for a pillow but the break of day found two of us off for help and it was three miles to the home of the Indian who came and pulled the car down the hill and turned it on a road which led to a lumber camp where the machine was righted and we went merrily on to the journey's end, where the mothers and babies were waiting.

A series of conferences in three places and at one County Fair were attended by appreciative mothers and fathers, and their display of real satisfaction and of keen interest about their children made a difficult journey seem very worth while. At one of the conferences a mother had come sixty miles from back in the hills, just to see the State Doctor. Worth while? I wish every citizen might come in personal contact with our State Bureaus of Child Hygiene and actually know how much is being done for the mothers and children through the efforts of the State Directors. The story is only

half told, but it perhaps gives a glimpse of the difficulties surrounding the extension of help to the rural mothers and children.

THE CHILDREN'S BUREAU ISSUES A DIRECTORY OF LOCAL CHILD HEALTH AGENCIES IN THE UNITED STATES

The Children's Bureau has sent out an incomplete directory giving general information concerning local public and private child health agencies active in maternity and infant care, and in the care of children of pre-school age. It is supplementary to the publications descriptive of national child welfare organizations, and, in order to avoid duplication of material, it merely gives references to information concern ing child health agencies already published in local directories.

The material was compiled by means of 1492 questionnaires which were sent out. Seven hundred and seven were not returned, though follow-up letters were sent. Undoubtedly it is impossible to obtain an absolutely complete list of this kind by means of the questionnaire method. As this work was from necessity done during the months of June to August 1921 inclusive, it is possible that the return of questionnaires has been delayed by vacation absences of many executives. In some cases questions were answered with apparent inaccuracy, especially in regard to personnel. Where no additional information from reports or other sources was available, statements are given as they appeared on the questionnaire.

The directory in its present form is temporary, and it is expected that it will be printed at a later date. In order to make the final form as complete as possible, corrections and additions are solicited and will be incorporated if received by the Children's Bureau before January 1st, 1922.

DENTAL HYGIENISTS

Miss Leete sends word that a new Division of Dental Hygiene was formed in the California State Department of Health on September 6, 1921, with Miss Charlotte Greenhood as supervisor. Miss Greenhood is editor of the Dental Hygiene News Letter, San Francisco.

A law recently passed in California provides for the licensing of dental hygienists. The law requires that an applicant for this position must be over eighteen and "shall present evidence of graduation from any regularly incorporated dental college, dental infirmary or any other institution of equal standing which maintains a course of instruction for dental hygienists equivalent in all respects to a similar course of instruction maintained in the University of California." The University of California will admit to its dental hygiene course a graduate of an accredited high school.

The Foreign Field

England

LOW INFANT MORTALITY

The infant mortality rate of London dropped in 1920 to 76 per 1,000 which compares advantageously with the rate of New York City, 84 per 1,000. (*School Government Chronicle, August 27, 1921.*)

DOCTOR PRITCHARD'S PAPER

In the Contemporary Review for July, 1921, Dr. Eric Prichard writes an able article on "Infant Mortality and the Welfare Movement", in which he explains the remarkable fall of nearly fifty per cent which has occurred in the infant mortality rate in England since the beginning of the present century. He concludes that it is due to the efforts of the State to improve general sanitary conditions, to the development of mothercraft methods, through conferences and clinics, and to the efforts of organizations for child care. In the last twenty-one years Doctor Prichard says, there is scarcely a single detail of child care that has not been fundamentally affected.

CANAL-BOAT CHILDREN

The effect of canal-boat life on children has been the subject of an investigation by a departmental committee appointed by the Minister of Health of England and Wales. The report states that so far as health, cleanliness, discipline, and so forth, are concerned, the children are at least as well off on the barges as they would be in town, and that no case has been established for the exclusion of children from the boats on the ground of excessive danger from accident or of unsuitable labor; but that their educational opportunities are hopelessly inadequate. It is estimated that half of these children do not attend school twenty half-days in a year. Many of the parents are illiterate and willing that their children should be so. In the special school for canal-boat children at Brentford, the only example of its kind in England, the pupils were said to show marked interest in their work and to progress rapidly, but they attend only about two or three days a month. The committee recommended that after a period of grace of one year, children of school age should be prohibited from living in canal-boats during school terms. (*London Times Educational Supplement, August 20, 1921.*)

Australia

The Report of the Principal Medical Officer of the Education Department of New South Wales for the years 1918-1919 includes the record of a valuable anthropometrical investigation into the rates

of growth and the heights and weights of Australian children. In New South Wales the special interest in such an investigation lies in the diversity of climatic conditions, and in the influence which this diversity is likely to have upon the bodily habit and growth of the population. Correlated with climatic diversity are the sociological differences due to the rise of centers of population where mineral wealth, or other industries have called men to live and labor. The graphs and tables which illustrate the report are based upon the measurement of 120,000 individual children. These are divided into three groups, viz.: those living in the metropolitan area, in the large country towns, and in the rural districts. This investigation "furnishes conclusive evidence that the fresh air and free life of the country child assists materially in the building of children of the largest physique * * * Boys and girls residing in country districts are both heavier and taller than children reared in the city and crowded suburban areas. More forcibly is this fact brought home when it is revealed that children living in rural districts, while of bigger physique than metropolitan children, are at the same time bigger all round than children assembled in large country towns."

The records also indicate a larger stature among children of Australian parentage than among those one or both of whose parents are foreign-born. (*The Medical Officer, September* 3, 1921).

Scotland

YOUNG DEAF CHILDREN

Sir Leslie Mackensie, member of the Scottish Board of Health, recently delivered an address at the 112th annual meeting of the Edinburgh Royal Institution for the Deaf and Dumb, making a special plea for the very early instruction of very deaf young children. Sir Leslie said, in part:

"It is the aim of this institution to secure younger children and so to lengthen the period of possible education, and to facilitate the application of modern methods. Another important fact is the care of the child that once spoke, but now, from long deafness, speaks no more. The gracious sounds that form the finest acquisition of mankind sink into "unintelligible gabble," merely because the father and mother knew too little or felt too little to seek out for their infant the best methods of conserving the voice.

"The language of sound is only one among many. * * * Where there is no eye to see and no light to see by, there can be no meaning in a gesture of the hand. Where there is no ear to hear, there can be no meaning in an uttered sound. And here is the problem of our deaf born infant: he may be able to speak; but he cannot hear. He can thus fling his cry for help into the human world; but he cannot hear the answering sound. Of the two essential organs, he is born with only one. From the depth of his inherited nervous organization

he has the wish and the power to speak; but, without the power to hear any answer, the wish goes out in despair and the power of speech ultimately dies, and the deaf born grows dumb. Our problem is, in spite of the deaf ear, how to keep alive the wish and the power to speak. This problem it is possible to solve, at least in some degree. The method of solving it is to make the eye a substitute for the ear. The infant's capacity to imitate the actions that it sees is incredibly great. If it were not so it would not be possible to teach lip-reading. But the problem is not merely to teach lip-reading. To a deaf child the motion of the lips has no more significance than the motion of the hand, and if it were only a question of imitation or interpretation of silent gesture, lip-reading would be relatively simple. Any child will make any "face" the teacher makes. The real problem is how to induce the child to inform his lip gestures with the sounds of the voice he possesses. This is the very point of the difficulty. * * *

"The nervous mechanism of significant speech is of infinite complexity; but it is as real in the brain as the mechanism through which we lift our hand to salute, or swing one foot after the other in walking. It is important to realize this with perfect clearness. Both in the spoken word and in the significant gesture, the mystery of meaning is the same. But realize clearly that the word, the sentence, the paragraph, the chapter can be analyzed and expressed in certain combinations of nervous and muscular actions. Then the problem of training in articulate speech is like the problem of training in the speech of gesture, namely, how to use a series of motions to express a meaning. It is through the series of motions visible to the eye that the teacher of lip-speech succeeds in saving the voice for one cardinal purpose, namely, the formation of sounds with meaning.

"When should the effort to save and develop the voice begin? The answer of experience is that it should begin as soon as the child is clearly known to be deaf, but shows evidence of the impulse to speak. Recently, at a Congress of Philosophy, Professor Head, of Cambridge, gave an account of his methods of treating disorders of speech among army officers affected by so-called shell-shock. He found that the most rapid progress was made where the impulse to speak still remained strong. In those cases, the recovery of ordered speech was much more rapid and successful. When the impulse to speak faded progress was difficult. It is the same with young children. Within the first three years of life, there comes to every child a 'babbling stage.' The infant has an irresistible desire to communicate its thoughts to others in words. This is true of all normal children and for the majority of children born deaf. At this stage,

in the normal child, language is acquired with a rapidity that surprises none more than the child's father and mother. It is the same with deaf children if they are otherwise of normal brain capacity, as many of them are. From the social nature of man, it may be inferred that the impulse to speak is universal. Last year, in honor of this idea, the directors opened a nursery school. It is too soon to speak of results; but, if experience elsewhere means anything, the teacher of lip speech working on the irresistible impulse towards expression, will bring forward with amazing rapidity the powers of articulation. The experiment is not, of course, entirely new; but it is new in the east of Scotland."

In speaking of the Philadelphia Home for the Training in Speech of Deaf Children, Sir Leslie says that Miss Garrett, the Principal, begins with children before they are of school age. Dr. James Kerr Love, of Glasgow, says, "between the ages of two and seven the hearing child is rapidly developing, the deaf child is at a standstill, and I have shown that, as a consequence, the deaf child's head is smaller than the head of the hearing child. This school takes the child at two or three years, and educates him by the oral method till he is able to enter the schools for the hearing. It must, therefore, be considered apart and not compared with other American schools. I found the children very anxious to talk to me; they spoke and lip-read very well. Altogether, I thought Miss Garrett's work admirable. I think it is sure to be copied in other countries."

ONE-ROOM HOUSES

Mr. John Robertson, M. P., recently told the House of Commons that 12.8 per cent of the total number of houses in Scotland consisted of one room each, and 40 per cent had but two rooms; that 400,000 people lived in these one-room houses and nearly 40 per cent of the population in those of two rooms. — (*The Medical Officer, August* 20, 1921.)

VOCATIONAL EDUCATION

Vocational education has acquired a new importance in Great Britain, says Mr. Kennedy-Fraser, of Edinburgh University, in view of two recent developments—the extension of the school age, and the discovery that an appreciable proportion of the general population is so subnormal in intelligence as to be unfit to profit by any general course of education devised to meet the needs of the average pupil over the age of 10. For children who make a very poor showing in intelligence tests, some form of pre-vocational training suited to their mental level is recommended. From an educator's standpoint, Mr. Fraser says, vocational training is needed, not in order to produce better clerks or workmen, but from the more fundamental consideration of the best means of development of the large number of children who

are bound to be misfits in a uniformly difficult curriculum.

India

A PHYSICAL EFFICIENCY TEST

The Lloyd Adams Fitness Shield, a graded physical efficiency test for Indian boys, was devised by the Y. M. C. A. with the purpose of raising the physical standard of a nation whose conditions of life for centuries have resulted in a weak physique. This test is in the nature of an athletic contest, in which each boys' school competes as a unit, the total strength of the school participating rather than a team or teams, and the smallest primary school having just as good a chance to win as the largest high school. The endurance, speed, agility, and strength of each entrant are put to the test. The fact that all pupils compete develops an unusual esprit de corps, and also results in concentration of effort by masters and good athletes on the weak members of the school, who must be trained and encouraged if the school is to succeed. The system is described in detail by H. G. Beall, Provincial Director of Physical Education for Hyperabad-Secunderabad, India, in the *American Physical Education Review, October,* 1921.

Argentine

Regulations for the physical education of school children which have just been approved by the National Council of Education, the central educational authority of Argentine, provide for special classes in physical education, for the installation of conveniently accessible playgrounds, and for the appointment of teachers for each playground. The council also ordered the appointment of a commission to draft plans for the construction of school baths. (*Anales de Instruccion Primaria, No.* 1-3, 1921.)

In order to relieve the housing situation the municipal council of Buenos Aires has passed an ordinance designed to bring into use such real estate belonging to the municipality as has not been built upon or is occupied by old and inadequate structures. This property will be handed over for a period of 25 years without any kind of annual rental or remuneration, to concessionaries who will be obliged to build thereon houses representing a minimum value of twice the value of the land. Exemption from the payment of current rates for lighting, etc., is provided for, and the maximum rent is fixed at 9 per cent of the capital invested. At the end of the 25-year period the buildings become the property of the municipality. (*Pan American Union Bulletin, October,* 1921.)

Bolivia

A decree providing school medical service throughout the country was recently issued by the national government. School physicians are to be appointed in the capitals of the departments and in the provinces. The school doctors will care for the health of the children and sanitation of the

school quarters, and at the beginning of each school year will make an examination of the teachers and pupils, classifying them as well, suspicious, and ill, with a view to the necessary treatment. The doctors are also to spread among the people the knowledge of hygiene, inform the parent's of their children's state of health, and issue the necessary sanitary regulations. The decree also provides for the appointment of school dentists and of women teachers of child care in the girls' schools. (*Anales de Instruccion Primaria, No.* 1-3, 1921.)

France

The National Ministry of Hygiene and Department of Athletics, created in France in 1920, are charged with the duty of building up a national system of physical education, sports, and social hygiene, with the purpose of insuring the future of the nation. The French Government has invited an American to collaborate with its National Committee of Physical Training and Sports. (*American Physical Education Review, October,* 1921.)

The establishment of separate divisions for adolescents in the employment exchanges of important cities is prescribed in a Circular of the Minister of Labor dated June, 6, 1921, on measures for the placement of children leaving school. These divisions are to be in charge of specially appointed committees. In the less important cities no separate divisions are necessary, a committee alone being sufficient. Members of the teaching profession are particularly well qualified for this work; therefore, in a circular issued on March 17, 1921, the Minister of Public Instruction asked the school authorities to aid the employment exchanges in their work with adolescents.

The Minister of Labor also prescribes physical examination of applicants for work, either by the school physicians, or, where such are not available, by the public health physicians. He urges cooperation with private child welfare agencies. (*Bulletin du Ministere du Travail Nos.* 4-6, 1921.)

The award of childbirth premiums to both married and unmarried mothers was decided upon by the Department of the Seine in April, 1921. To be eligible for the premium, a mother must have lived at least three years in the department and must have at least two living children. The amount is 400 francs for the third child and increases 50 francs for each additional one up to the tenth, for whom it is 750 francs. It is paid in two installments, 150 francs one month after the child's birth, and the rest when the child is a year old. This benefit is offered to all families, irrespective of their economic condition. (*Revue Mensuelle de l'Oeuvre Nationale de l'Enfance, August,* 1921.)

Amendment of the law of 1874 on protection of placed-out children under two years of age is proposed in several bills recently introduced.

One provides for supervision not only over that group but over all children under the age of two years whose parents receive public charitable aid. It also makes the first provision for a card index supplying definite information with regard to the up-bringing of these children. The local mayor would sign the cards at prescribed periods. If he discovered that some requirement had not been complied with, he would report the fact to the prefect, who would then take the necessary measures. Supervision over the children to whom the bill applies would be made much more thorough than the existing laws require. The bill calls for an added measure of cooperation by the public health service and various child welfare agencies, especially the infant consultation centers. (*Journal Officiel, Doc. Par. Senat,* 1921, *p.* 834.)

Belgium

The Children's Bureau of Belgium has issued its first annual report. The bureau was established by the law of September 5, 1919, with authority to grant subsidies to various child welfare agencies if they complied with certain conditions. Before the end of 1920 the bureau had approved 772 infant consultation centers caring for over 70,000 infants in 687 communes; 703 milk stations aiding over 65,000 children in 626 communes; 388 mothers' canteens feeding nearly 20,000 women in 353 communes; 47 school lunch rooms serving over 50,000 children in 41 communes; and 50 lunch rooms for feeble children feeding over 11,000 such children in 49 communes. The cost of maintenance of these institutions is furnished one-half by the State, one-fourth by the province, and one-fourth by the commune. The amount distributed in subsidies approved by the Children's Bureau during 1920 was 9,728,981 francs.

In addition to its practical work, the Children's Bureau, through its Superior Council on Child Welfare Agencies, studied in 1920 a number of questions connected with child welfare, such as milk production, maternity homes, nursing rooms and lunch rooms in factories, illegitimate children, and supervision over placed-out children. As a result of these studies some measures have already been taken for better handling of milk, more efficient care of placed-out children, and more thorough registration of births and deaths. (*Revue Mensuelle de l'Oeuvre Nationale de l'Enfance, June and July,* 1921.)

Italy

A new open-air school with accommodations for 1,700 children will soon be set in operation by the city of Milan on the site of the former trotting race course near the Viale Padova. The stables, grandstand, and so forth, have been adapted to use as motion-picture halls, kitchen and so forth. The

race course will be used for bicycling and running, and its center has been prepared for football, tennis, skating and swimming. New construction includes twelve one-storied pavilions of the Swiss chalet type raised about four feet from the ground. Each of these is planned to house one hundred and forty children and contains classrooms intended for winter use, lessons being given outdoors whenever the weather permits. The school is intended for delicate and ailing children from the various municipal schools. Its aim is to give them not only medical treatment but education in the conditions of healthy living. (*London Times Educational Supplement, September* 24, 1921.)

A new course in school hygiene was recently opened at the Institute of Hygiene of the University of Genoa. The course, which is given with the approval of the public health authorities, is open to physicians only and is free of charge. The applicant must promise regular attendance. (*La Protection de l'Enfance, July,* 1921.)

Germany

An amendment to the maternity benefit law, necessitated by the depreciation of the currency, was enacted by the Reichstag on July 7, 1921. The confinement benefit was raised from 50 to 100 m., the maternity benefit from 1.50 to 3 m. per day, and the nursing benefit from 75 pf. to 1.50 m. daily. In addition, women are to be given free medical treatment, when this is necessary because of pregnancy complications or during confinement.

The law provides the above benefits, not only for insured women, but also for every non-insured woman whose annual income is not over 10,000 m. for herself or herself and husband and 500 m. for each child. Under the old law the limit was 4.000 m. (*Soziale Praxis, July* 20, 1921.)

Health conditions in Germany in the summer of 1921 are authoritatively declared to have been satisfactory to a considerable degree. Although tuberculosis mortality, which within the thirty-year period ending in 1914 had been reduced one-half, in 1918 almost reached the rate of 1890, and continued to rise, it is believed that the energetic measures being taken against it will soon result in checking this excess. Diseases of alcoholic origin have very largely decreased. The infant mortality rate has resumed the downward progress maintained for years until its brief interruption after the war; the mortality of children from 2 to 14 years of age is slowly decreasing after its wartime increase; and the excess of births over deaths has risen since the war. The only serious health problem against which progress cannot be claimed is that of venereal disease, which spread extensively during and after the war. (*Soziale Praxis, July* 27, 1921.)

Recent Literature on Mother and Child Welfare

Suggestions for a Program for Health Teaching in the Elementary Schools. By J. Mace Andress and Mabel Bragg. Bureau of Education, Department of the Interior, Washington, D. C. Ten cents a single copy, six cents for each additional copy.

The need of a sound program of Health Education is insistent and the Bureau of Education has prepared suggestions for such a program for elementary schools, expressing the hope that "teachers, parents, and others interested in the health of the school child will study it with care, test it through school and home practice, and make definite and constructive criticisms and suggestions," for the program is presented merely as a basis for wider experimentation. Its purpose is (1) to define the goal for an effective program of Health Education in the schools; (2) to analyze the various factors of school and community that form an integral part of this program and the contribution that each, properly co-operating, may be expected to offer; and (3) to outline in a general way the school health activities and the methods of teaching that may prove successful.

The work described in the pamphlet has been demonstrated by grade teachers in the class room and found practicable. Ways and means have been developed to interest children, for as the new Commissioner of Education recently stated in speaking of Health Education, "The question is, how can children be trained in the practice of health habits? First of all the intense interest of the children must be won. The Bureau of Education is working upon a system of health teaching designed to create this interest among the children." And this most recent of the Bureau's Health Education pamphlets sums up, as it were, the result of their three years work along this line.

Public Health Reports. Issued weekly by the United States Public Health Service, Treasury Department, Washington, D. C. Vol. 36, No. 40 October 7, 1921, contains three special articles

Diphtheria Immunization is a short description of the Schick test for immunity to diphtheria, its purpose and method of application. The article is followed by a list of references.

A report on the Second English-Speaking Conference on Infant Welfare is a twelve page summary of the proceedings of that Conference held in London, July 5-7, 1921, by Dr. Taliaferro Clark of the United States Public Health service. The Cooperative Rural Health Work of the Public Health Service in the Fiscal Year 1921, is described by Dr. L. L. Lumsden.

HAPPY'S CALENDAR

The Child Health Organization of America has already introduced Happy to thousands of children, and is now publishing his calendar, which will make him the friend of thousands more.

A school boy's calendar begins in September and ends in June as any self-respecting calendar for boys and girls should. July and August are just an "amazing interlude".

When Happy is in civilian clothes he is called Cliff Goldsmith, and both these names appear on his calendar. Jessie Gillespie, who has the gift of making droll sketches that delight children everywhere, has illustrated the calendar.

CHO-CHO'S HEALTH GAME

When night has come and the children are all snug in their homes, they like to play indoor games. This is the time to bring out Cho-Cho's Health Game, prepared by the Child Health Organization of America from the Child Health Alphabet. The trouble is the game has proved so fascinating that children everywhere are begging for "just a few minutes more, please mother, till we finish this hand".

The game consists of 52 miniature cards, printed on shiny card board in bright colors, and packed in a cunning little box. The rhymes and pictures arranged by Margaret Gieb from the "Child Health Alphabet" have been cleverly used to furnish for children both an absorbing game and a lesson in health. Instructions are in every box.

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Proclamation

BY THE

MAYOR OF NEW HAVEN

We all agree that the promotion of the health and the prevention of disease as well as the conservation of health of the children of this community are matters of the gravest concern to all well-thinking people.

A healthy, virile childhood means future strong and vigorous manhood and womanhood. It is the duty, therefore, of all interested in the welfare of the city to do all within their power to aid and assist in the development of that service which produces lasting benefits to the childhood of the city.

As mayor of the city of New Haven, I therefore respectfully request that the people of this great city participate and take part in the coming twelfth annual convention or meeting of the American Child Hygiene Association, to be held here on Nov. 2 to 5 inclusive. Let our people by their earnest co-operation demonstrate to those who are actively and energetically engaged in this great work, which means so much for humanity, that the community is behind them, and anxious to co-operate and assist in the cause which they have at heart.

I urge, therefore, a whole-hearted participation of the people of the city of New Haven.

Dated at New Haven this 1st day of November, 1921.

DAVID E. FITZGERALD
MAYOR.

MOTHER AND CHILD
A Magazine Concerned With Their Health

VOL. II. DECEMBER, 1921 No. 12

American Child Hygiene Association and the Development of the Child Hygiene Movement

Henry L. K. Shaw, M. D. Albany, New York

THE American Child Hygiene Association meets today on historic ground. Twelve years ago, in this city, our Association came into existence as a crystallization of a country wide but unorganized sentiment demanding the protection of infancy,—a square deal for the baby. The need for such an organization was discussed in Chicago in the Spring of 1908 at a meeting of the American Academy of Medicine. A committee was appointed with power to arrange and conduct for the Academy, a Conference on the Prevention of Infant Mortality, the purpose being primarily to direct public attention to this problem by bringing together the experience of various social agencies dealing with it. This proposed Conference was held in New Haven on the 11th and 12th of November, 1909. At its close this Association under the name "The American Association for the Study and Prevention of Infant Mortality" formally came into existence with the adoption of a constitution and election of officers. It is of interest to note that of the 29 original Directors 10 now serve on the Board and the Executive Secretary and Treasurer still remain in office. The objects of the Association as stated in the constitution were:

1. The study of infant mortality in all its relations.

2. The dissemination of knowledge concerning the causes and prevention of infant mortality.

3. The encouragement of methods for the prevention of infant mortality.

The name of the Association was changed to that of the American Child Hygiene Association in January, 1919, in recognition of the fact that its problem was not alone one concerned with infant mortality but that its scope had broadened and included the welfare of the child from conception to adolescence. The objects under this wider program can be restated as follows:

1. The study of child hygiene in all its phases.

2. The dissemination of knowledge concerning maternal and child hy-

Presidential address at the Twelfth Annual Meeting of The American Child Hygiene Association, New Haven, November 2, 1921

giene and the methods of preventing mortality and morbidity among children.

3. The stimulation and encouragement of measures for promoting the health of mothers and children.

In order to determine the influence which this Association has exerted on child hygiene activities in this country and to what extent its objects have been attained, we should glance briefly at conditions as they existed in the United States prior to 1908 and compare them with the present conditions.

When Dr. Helen Putman, of Providence, presented the resolution in 1908 at the Chicago meeting which led to the formation of this Association there were no organized efforts to combat the very high infant mortality in the cities of this country. There had been some spasmodic, crude and widely separated attempts but there was no system, no coordination and no medium for the interchange of ideas and methods. Most of the work consisted of supplying modified and pure milk for babies, and this was carried on largely by private agencies and in only a few cities was money appropriated for this purpose by the municipality. At that time no city or state health departments had divisions of child hygiene. There was no prenatal or preschool age work and medical school inspection consisted almost entirely in excluding contagious disease and making perfunctory physical examinations which had little effect in improving the health of the child.

The vital statistics for births, still births and deaths under one year of age were reliable in only a very few of the large cities. The United States Census Bureau had no recognized birth registration area and in 8 states where birth registration was fairly complete the infant mortality rate in 1910 varied from 108 to 168 per 1,000 living births for the same period. This same year the Census Bureau estimated the infant mortality rate for the entire United States as 149. For the sake of comparison the rate for England for 1910 was 109 and in New Zealand the infant mortality rate was only 65.

Such was the general situation at the time of the first New Haven meeting. In marked contrast is the situation at the time of this second New Haven meeting.

The United States Public Health Service, previous to the organization of this Association, had been engaged in pioneer work in improving conditions which affect the environment of the child such as controlling the spread of epidemics, safe-guarding the milk supply. Later it became interested in the health of the child and the prevention of defects. A number of excellent popular educational leaflets on motherhood, feeding, malnutrition, etc., have been published and given large circulation. A pamphlet on the care of the baby prepared by a committee of this Association was printed as a supplement to the Public Health Reports and

has been widely distributed. There has always been close cooperation and affiliation between the Public Health Service and this Association. This work now is largely under the personal direction of Dr. Taliaferro Clark whose practical knowledge of child hygiene work and administrative ability have made this branch of the Public Health Service a factor in the solution of child hygiene problems in this country. This Association was honored by having Dr. Clark its official representative at the London Conference on Infant Mortality last July.

THE CHILDREN'S BUREAU

There is the most active and energetic Federal Children's Bureau which was created in 1912 for the purpose of "Investigating and reporting on all matters pertaining to the welfare of children and child life among all classes of people." Under the effective leadership of Miss Julia Lathrop, who has just resigned after nine faithful years of service, this Bureau has taken a foremost part in child hygiene work in this country. President Hadley, of Yale University, in conferring the honorary degree of Master of Arts upon Miss Lathrop in recognition of her services in Child Welfare, referred to her as "a fearless humanitarian whose career is a public blessing."

Thirty-eight states have special divisions of Child Hygiene in the State Health Departments showing that these States now recognize their duty and obligation to the children of the coming generation. These divisions are concerned with educational work and in promoting, supervising and protecting the health of babies, expectant mothers and little children. Forty-five cities now have special divisions of child hygiene to guard the interests and the health of its future citizens. New York City in August, 1908, was the first to establish such a division and Dr. S. Josephine Baker was placed in charge. Dr. Baker has achieved international reputation as a result of her administration of this Division. She blazed the trail and did pioneer work which served as a model for municipal and state divisions of child hygiene which were organized later. Dr. Baker was president of this Association during the trying days following the close of the war, and its existence today is largely due to her earnest work and zeal which carried it through the reconstruction period. The results achieved in New York are shown by the fall in the infant mortality rate from 144 in 1908 to 85 in 1920, a reduction of 59 points in 12 years.

LOWER DEATH RATES

Other cities followed New York's example with striking results. Boston with an infant mortality of 148 in 1908 reduced it to 101 in 1920. Philadelphia with 144 in 1908 had an infant mortality of 91 in 1920. Cleveland with 150 in 1908 had 87

in 1920. Buffalo with 143 in 1908 reduced it to 103 in 1920 and Detroit with a high score of 181 in 1908 was able to bring this figure down to 104 in 1920.

Dr. Holt in an address before this Association asked: "Does God fix the death rate? Once men were taught so, and death was regarded as an act of Providence, often inscrutable. We are now coming to look upon a high infant death rate as evidence of human weakness, ignorance and cupidity. We believe that Providence works through human agencies and that in this field, as in others, we reap what we sow —no more and no less." The results accomplished in these cities through "human (child hygiene) agencies" confirm Dr. Holt's statement and are a challenge to other cities in the country.

The Census Bureau now has a birth registration area embracing 23 states in which at least 90 per cent of the births are reported and the estimated infant mortality rate for the entire United States in 1920 was 86, a drop of 63 points, or 42 per cent in ten years.

We have seen that very little child hygiene work was being done in the United States prior to 1908. In Europe, however, the awakening took place much earlier. France has always taken the lead in the organization of public and private activities for the reduction of infant mortality.

FRANCE TAKES THE INITIATIVE

Professor Marfan, of the University of Paris, calls attention to the fact that the Societe de Charite Maternelle was founded in Paris in 1784 by Madame de Fougeret the aims of which were to prevent abandonment of children, to assist mothers during confinement, to aid them in the care of the infants and to protect the infants from the evils that menace them. It is interesting to note that this society is still in existence.

The Societe Protectrice de l'Enfance was organized in Paris in 1876 to encourage maternal nursing, watch over infants sent out to wet nurses and instruct the mothers in the care of children. In the same year the Societe de l'Allaite-

The increase in the number of local child hygiene societies which are affiliated with this Association is most gratifying. Thirty-three affiliated societies and 503 members joined the Association in 1910, the first year of its existence. The Association has always sought the cooperation of these local societies and it is most encouraging to note that we now have 273 affiliated societies and 2003 members. This is very definite proof that the Association has not been found wanting when weighed on the scales of service.

ment Maternel was formed with the object of giving aid to mothers while nursing their babies.

The French Parliament passed a law in 1874 called the Roussel law after its introducer, which among other provisions contains a clause destined to encourage breast feeding in that no woman could take a position as wet nurse until her own child was seven months old or breast fed by another woman. It also gave the public authorities power to inspect the surroundings of any child under two years of age placed out to board by its parents. This law was the first instance of state intervention in the supervision of infants not committed to public charity.

THE FIRST DAY NURSERY

Day Nurseries have been popular in Europe for many years and the first Day Nursery or Creche* of which we have any record was established in Paris in 1844. Mrs. Arthur M. Dodge, President of the Federation of Day Nurseries, gives a most interesting account of the origin of the Day Nursery idea. "A renowned Protestant pastor, Johann Oberlin, traversing one of the little villages of his native Vosges, on a bright harvest day in 1769, heard from a hut a chorus of childish voices. Entering he found a group of children seated around a girl of eighteen, who sang while spinning her thread. She was caring for the little ones whose mothers were in the fields. He grasped the conception of a social institution and engaged this girl, Louise Scheppler, to organize in his presbytery "Une Garderie", where during working seasons children between the ages of 15 days and 3 years might be cared for while the parents were at work".

Improper feeding and impure milk were considered the chief causes of infant mortality in the latter part of the 19th century. For this reason the early attempts to remedy this condition were to provide sterile modified milk for babies. The credit of first providing free distribution of modified milk for infants belongs to the United States, as the Good Samaritan Dispensary in New York, in 1889, under the direction of Dr. Koplik, furnished such milk to needy infants. The first attempt in Europe was made three years later, in 1892, by Dr. Variot at the Belleville Dispensary in Paris. Two years later Dufour in Fecamp established a depot for babies' milk as a separate institution not connected with a hospital or dispensary and gave it a striking and original name "Goutte de Lait." According to Dr. McCleary, of London, the idea of advising and instructing mothers originated in

*Sir Leslie MacKensie has called attention to the fact that the French term creche, derived from the old High German krippja, originally meant a manger for animals; specialized to mean the birthplace of Jesus; specialized still further as an asylum for foundlings; later, as an asylum for infants of the poor during the time the mother is absent at work.

1890 with an obstetrician, Professor Herrgott, of Nancy. He required the babies born in his obstetrical hospital to be returned for examination for one month after birth and if the progress was satisfactory the mother received a gift of money. Professor Budin, at the Charite Hospital in Paris, established in 1892 the first Consultation de Nourrissons. He developed and extended the idea of Professor Herrgot and had the babies brought to the Consultation once a week until the baby was a year old. He emphasized the importance of breast feeding and made a point of instructing the mothers in how to properly care for their babies. It was Budin who said that the Consultation was worth just as much as the one at the head of it.

The results compared with unsupervised babies were so striking that new consultations and Gouttes de Lait sprang up all over Europe. The seed sown by Koplik, Variot, Budin and Dufour fell on fertile ground and similar efforts were soon started in nearly every civilized country. In the process of evolution the educational features were emphasized and the provision of milk became less important. Today the mother brings her baby to the center for examination and advice, for what she can learn and not for what she can get.

The discussion of methods, the recording of results and the interchange of ideas are greatly facilitated through National and International Organizations and Conventions.

The first national organization directed to the reduction of infant mortality was founded in Paris in 1902. This was called the Ligue contre La Mortalite Infantile. The aim of this league was to develop agencies already in existence and to create new ones to lower the death rate of babies. In 1903 the Ligue Nationale Belge pour la Protection de l'Enfance du Premier Age was established in Brussels. The Deutsche Vereinigung fuer

> At a meeting of the French Academy of Medicine one of the speakers stated that Professor Budin had been the means of saving a battalion from the slaughter field of infancy. Dr. Simpson of London in commenting on this in 1906 wrote in prophetic words "if, in the days of the rising generation, folly should be allowed to override wisdom, and the dogs of war howl down the counsellors of peace, the place that France would take on emerging from a great world strife might depend largely on the strength of Budin's battalion".

Saueglingsschutz was formed in Berlin in the Spring of 1909, a few months before the organization of this Association.

In England a National Conference on Infant Mortality was held in London in June 1906 and was the first serious attempt to bring to the attention of the public the deep significance of the unnecessary loss of Great Britain's prospective and potential citizens. This Conference met with such great interest and support that others have been held in 1908, 1913, 1914 and 1921.

INTERNATIONAL CONGRESS

The first International Congress concerned with infant hygiene was held in Paris in 1905. Surely the baby was coming into his own when he was considered of enough importance to be the subject of an International Congress. The second Congress was held in Brussels in 1907 under the name of Congress pour le Protection de l'Enfance du Premier Age and was one of great value in stimulating public interest in the protection of child life.

The third International Congress was held in Berlin in 1911 and at this meeting it was planned to hold a Congress every four years but this plan could not be carried out on account of the war. At the first Congress a Committee was appointed to organize an International Union for the Protection of Infants under One Year of Age.

It is unfortunate that confusion has arisen between the terms Child Hygiene and Child Welfare. Child Welfare devotes its activities to the problems of delinquency, dependency and moral and mental deficiency while child hygiene concerns itself with the physical and mental health and health problems from infancy to adolescence. The terms as now employed are not synonymous or interchangeable as each refers to a separate and distinct line of endeavor.

The increase of child hygiene activities during the past twelve years both in this country and in Europe has been phenomenal. The modern child hygiene center marks the most striking advance in our campaign against infant mortality and morbidity during the past decade. This has changed from a place where only milk was distributed to a well organized center from which radiates instruction and advice not only for the baby but the prospective mother and the little toddler. The support of these centers is now very largely carried on by public funds while twelve years ago the few then in existence were practically dependent on the uncertainties of private philanthropy.

The municipalities—even the National Government itself—had not been aroused twelve years ago to the tremendous social, economic and political importance of saving the babies of the Nation. Public Health and Sanitary reforms which had been so successful in the past 50 years in reducing the general death rate and controlling epidemics were

considered sufficient to reduce the infant mortality. Such measures as the control of water supplies, improved methods of sewage disposal, supervision of the milk supply, cremation of garbage and wastes and other sanitary reforms exerted no appreciable effect on the infant death rate. The environment was improved at great effort and expense as has been pointed out by Dr. Eric Pritchard, of London; but still the babies died. This problem had not been solved until the necessity of instructing and dealing with the individual mother and her baby became recognized.

England's pride in the physical strength of her young manhood received a severe jolt during the Boer War when it was found that a majority of the recruits were physically incapacitated for military service. When searching for the cause they looked into the school age period and found the defects existed before the boys entered school and that they were present even in infancy. They finally discovered that the prenatal period must be guarded and supervised and proper obstetrical facilities provided in order to prevent physical defects and debility and to insure a stronger and more enduring manhood in the next generation. This conclusion was voiced by John Burns at a meeting of the English Conference on Infant Mortality when he said: "Give us good motherhood and good prenatal conditions and I have no despair for the future of this or any other country. I believe that what the prenatal condition of the mother is, so her offspring will be. The stream is no purer than its source. Let us glorify, dignify and purify motherhood by every means in our power." Tennyson voiced the same sentiment.

"The woman's cause is man's. They
rise or sink
Together. Dwarf'd or Godlike—
bond or free:
If she be small, slight natured, miserable
How shall men grow?"

To develop and encourage prenatal work has always been an important part of our program and the rapid spread of this work not alone in the cities but also in the country districts is largely the result of educational propaganda launched by this Association. The prenatal clinic today is an integral part of the functions of a child hygiene center and it was unheard of twelve years ago.

MORE CHILD WELFARE CENTERS

For the first few years the efforts of the Association were chiefly directed to awakening the American people from their lethargy and indifference towards the unnecessary loss of infants' lives. Baby Saving Shows were held in nearly all of the large cities and the Association prepared a traveling exhibit which it lent to the smaller communities. Newspaper articles, lectures and demonstrations were

used in arousing public sentiment and in urging communities to establish child hygiene centers. When the Association was formed there were only 43 infant milk depots in 30 cities according to a Survey made in 1910 by the United States Public Health Service. Today it is impossible to obtain reliable data concerning the number of child hygiene centers in the United States; but in New York State there are now 185 centers in active operation in 57 communities of which over 80 per cent receive municipal aid. We cannot pride ourselves on our progress when we compare it with what has been done in Europe. There were in England and Wales about 250 child hygiene centers in 1914 and the infant mortality rate was 105 while in 1920 there were nearly 2,000 centers and the infant mortality rate was 80. Belgium has set us a wonderful example and Rene Sand, an honorary member of this Association, describes the situation very clearly. "War broke out and the future of the race was imperilled. The need to protect children became urgent and in the midst of the most difficult circumstances, German tyranny, scarcity of supplies, difficulty of transport and scarcity of hands, there sprang up a child welfare organization which reaches the tiniest villages and surpasses anything ever dreamed of in time of peace. In 1914 we had in Belgium 70 infant welfare stations; there are now (1920) 768, and they have distributed over a billion gallons of milk mostly to the mothers, as 83 per cent of the children were breast fed * * * The results were quickly felt; instead of increasing, infant mortality diminished in the occupied parts of Belgium". The infant mortality rate for 1914 was 151 and 82 in 1919.

The past twelve years has seen a decided change in sentiment among physicians in regard to social medicine and child hygiene work. Medical men were so concerned with the study of the sick child they gave but scant attention to the well child or to measures directed to keeping him well and preventing disease and defects. Medical school students were taught little or nothing about infant mortality and its prevention except perhaps the number of deaths from disease and malformation. This led them to attach an exaggerated importance to disease and pathologic changes.

The American Pediatric Society was organized in 1889 for research and scientific study of disease in children, and its members showed but little interest in child hygiene and for many years no papers were presented on the subject. Several years ago there came a change in sentiment and papers on different phases of child hygiene were read and freely discussed. This change of sentiment may have been due to to the fact that 20 of its members are Directors of our Association and five have held the office of President. Three years ago a special Committee on Child Hygiene

was appointed by the Pediatric Society and this committee prepared a syllabus on Child Hygiene which has been accepted and adopted by many medical colleges. The influence of this teaching will be far-reaching and today the young doctor enters upon the practice of his profession with a working knowledge of child hygiene and preventive medicine and capable of taking charge of a child hygiene center and instructing the mothers how to keep their babies well.

The first program of this Association states that "membership is open to all who are interested in the baby. It is not limited to physicians, investigators, nurses, social workers or associations which deal directly with the problem of the prevention of infant mortality, but it is hoped that the fathers and mothers of the children who are getting a square deal will consider it a privilege to further the cause of less fortunate children."

The initial period in child hygiene work was chiefly medical and this Association had its origin in the American Academy of Medicine.

> Parallel with the change of sentiment in the medical profession has come a similar advance in the nursing profession. The nurse carries the lamp of knowledge into the homes which ignorance has darkened. Her work is done in the front line trenches where it often merits the Distinguished Service Medal.

A further example of the change in medical sentiment towards child hygiene work is seen in the action of the British Medical Association which appointed a committee to investigate and report on the value of child welfare work. This Committee submitted a report at its 1920 meeting and among the conclusions were: That child hygiene activities have contributed in an appreciable degree to the reduction of infant mortality: That the effect of many of the causes of infant mortality can be lessened by the education of women at the centers and in their homes: That the primary object of child hygiene centers should be educational, preventive and advisory and that no treatment be administered.

The period of study and investigation appealed more strongly to what might be termed the professional group comprising physicians, health officers and social workers.

The Children's Bureau with the assistance of women's clubs throughout this country organized a campaign in April of 1918 "to save 100,000 babies and get a square deal for children." It was designated Children's Year. This was made a nation wide weighing and measuring test for young children.

Millions of children were examined and a great popular stimulus was given to all child hygiene move-

ments. In the spring of 1919, a notable conference on Child Welfare Standards was held under the auspices of the Children's Bureau. European experts were invited as well as the leading authorities in this country. A series of standards for both child welfare and child hygiene programs were adopted after a full discussion at the Washington Conference and at eight others in different sections of the country.

VOLUNTEERS NEEDED

The present period in Child Hygiene work is characterized by the entry of large numbers of lay workers, a non-professional group, in the work of child hygiene. One of the results of Children's Year was to interest thousands of women in this great subject. Mothers' Clubs, Parent-Teacher Associations, Women's Clubs and other societies are phases of work in behalf of children, and they should not only become identified with this Association, but they should take a leading part in planning and carrying out its program.

The professional group has been in control too long. The Board of Directors number eighty-five and at present sixty-five are physicians, six nurses, eight social workers and there are only six non-professionals. This is not a healthy division; in fact, it is pathologic and might be diagnosed as pernicious professionalism, and a transfusion of laity is necessary to sustain its life and enable it to fulfill its responsibilities.

David Starr Jordan once said "There is nothing in all this world so important as children, nothing so interesting. If you ever yearn to be wise, study children. If you ever wish to go in for some form of philanthropy, DO something for children."

DO SOMETHING FOR CHILDREN

This is the appeal today. Do something for children! There is a place for every one in this Association. Volunteer workers and societies with the best intentions and greatest willingness need to have counsel and advice from persons trained in child hygiene work. This Association has trained and experienced workers who go into various localities and after studying the conditions give the lay workers the benefit of their knowledge and experience.

The popularity of doing something for children is shown by the existence of no less than 64 national organizations directly interested in some phase of child hygiene work. There was no team work and all worked independently and often in ignorance of what the others were doing. A centralized administrative control was necessary to give expert and scientific direction. This was accomplished a little over a year ago when the National Child Health Council was formed.

The creation of this Council is one of the most progressive steps in child hygiene work in recent years. The Council is now engaged in

bringing about closer cooperation and coordinating these various activities so that child hygiene work in the future will be conducted with greater efficiency and less wasted effort.

It would seem that the time has arrived for consolidation of a number of organizations having similar purposes and policies. Many of the societies are striving for members and struggling for existence. A consolidation would be in line of good business methods and would result in greater economy and prevent duplication and overlapping of efforts and aid in the development of new plans and methods.

Two years ago the Association was launched into a sea of broader usefulness and wider endeavor. The work up until this time had been carried on largely by correspondence and through an Annual Meeting. The new program includes the services of a full time General Director, a traveling Field Director, publication of the monthly journal, "Mother and Child," and increasing the executive and administrative staff. The chief functions of the Association under this new program in brief are,—to investigate state or local needs along child hygiene lines, to formulate practical working plans to meet these needs, to demonstrate the possibilities of constructive activities, to assist in their promotion and to foster education in child hygiene among parents, students, nurses, physicians and the general public.

We must now have the active and enthusiastic interest and cooperation of each member in order to attain our purpose under the new policy we have adopted. We can no longer rely on the efforts of officers of the Association if we are to arouse the nation to its responsibility towards its young children, and stimulate its efforts to improve their condition.

Charles Kingsley once said that too often it is stupid indulgence, stupid neglect and stupid ignorance and not the will of God that brings these little ones to an untimely end.

The growth and influence of this Association are largely dependent on the number and devotion of its members. We need more—many more members and affiliated societies and we can render no greater service to the Association than by increasing its membership through personal solicitation. Much has been accomplished in the past twelve years but we stand only on the threshold of possibilities in child hygiene. Before us lie many unsolved problems offering vast opportunities for service. Herein lies our duty, our responsibility and our inspiration.

Let us therefore both as individuals and as members of the American Child Hygiene Association strive to meet our obligations to the coming generation and to bear in mind that it is not the will of the Father in Heaven that one of these little ones should perish.

The New Haven Meeting of the American Child Hygiene Association

TWO reasons were urged for the propriety of holding the twelfth Annual Meeting of the Association in New Haven. Both were good reasons. The first was that this Association, the germinal center for all Child Welfare Activities in the United States, first met and organized in the shade of the New Haven elms; the second, that as child hygiene work is essentially a work of education, no more fitting place for such a meeting could be selected than the great Yale University. Both reasons have been justified fully. The Association assembled in New Haven on November 2nd, and no more successful, or enjoyable, or generally satisfactory meeting has been held in its history. There was a total registration of four hundred and seventy-six, twenty-seven states, the District of Columbia, Hawaii, Canada, England, and France having representatives present. At none of the general or section meetings were vacant chairs in evidence, and as the program moved on, it became increasingly difficult to find room for those who were tardy.

The enthusiastic welcome of the municipal authorities, of the Faculty of Yale University, of the public health organizations of the city, and of the press and the citizens of New Haven generally was manifested in the smooth and successful functioning of every detail of a long and detailed program.

The gracious hospitality of the New Haven Visiting Nurse Association at the tea which they gave in their fine old home on Thursday afternoon gave the delegates and members an opportunity to meet soon after arriving in New Haven. The Graduate Nurses' Association entertained at the Hotel Taft on Friday.

THE GENERAL SESSIONS

The general sessions were conducted in Sprague Memorial Hall and the Lampson Lyceum of Yale University. The opening session on Wednesday, November 2nd, presided over by Mr. Courtenay Dinwiddie, Washington, D. C., was devoted to "Co-ordination of Child Health Activities."

Dr. Haven Emerson, of New York, Dr. Walter Brown, of Mansfield, and Dr. Philip Van Ingen, of New York, discussed the situation from the angles of local, state and national health work. The discussion that followed these authoritative papers, was spirited and stimulating.

The President of the Association, Dr. H. L. K. Shaw, of Alba-

ny, presided at the morning session at Sprague Memorial Hall on Thursday. His address, which appears in this issue, was enthusiastically applauded. The report of the General Director, Dr. Richard Bolt, "Progress of Child Hygiene Work in the United States" was a retrospect of accomplished work of the past year, that was remarkable in its variety as well as its scope.

Dr. Anna Rude, of the Children's Bureau, Washington, D. C. and Dr. Julius Levy, of Newark, added much of interest in discussing Doctor Bolt's report.

THE AFFILIATED SOCIETIES

The roll call of affiliated societies showed an attendance eclipsing that of previous meetings. Some organizations had as many as seven or eight representatives on the floor, and considerable friendly rivalry developed as to which individual society could muster the largest group attendance.

The subscription luncheon for nurses was held in the grill room at the Hotel Taft on Thursday at twelve-thirty and was an informal function which was thoroughly enjoyed by the nursing group.

The general session on Thursday was presided over by Dr. Haven Emerson, in the absence of Dr. Thomas Finnegan, of Harrisburg.

Miss Edith Pye and Dr. Hilda Clark, of England, who have been doing relief work under the auspices of the Society of Friends, spoke at length on the pitiful condition of Austrian children as a result of the war. Their account of the noble and disinterested work in which their organization is engaged was warmly applauded.

Mrs. Charles Remington, of Providence, spoke on "The Home and Child Hygiene"; Miss Julia Wade Abbot, of the United States Department of Education discussed "Health Habits in the Kindergarten", and Mrs. Arnold Gesell, of New Haven, read a most original paper on "The Psychology of Health Education". The discussion elicited by these speakers showed that the Association had struck a new note in its program in realizing the essential educational character of this work and discussing the principles underlying methods of teaching health to the individual child. This was further developed in the session on Friday afternoon at Lampson Lyceum, where Dr. William Palmer Lucas, of San Francisco, presided. At this Friday session Dr. C. Macfie Campbell, of Harvard University, read a paper on "The Psychology of the Pre-school Period", while Miss Margaret Roche, R. N., of Grand Rapids, talked on "The Recreation of the Pre-school Child". Spirited discussion followed Doctor Campbell's paper. The brief but interesting talk on "Day Nurseries" by Mrs. Laurence Hamill, of Cleveland, with illustrative mo-

tion pictures, showed the opportunity which these establishments may furnish to those who would study and correct defects in the child of pre-school age.

THE LAY DIRECTORS SESSION

A new and very popular meeting was the one devoted to "Problems and Opportunities of Lay Directors of Private Organizations". Mr. George R. Bedinger, of New York, presided, and the attendance of a large number of lay directors as attested by a showing of hands on call from the chair, showed that this new section was filling a definite need in the Association. At this session which began on Friday morning at ten o'clock, Dr. Roger I. Lee, of Cambridge, read a thoughtful paper on "The Value of Lay Co-operation in Health Work". Mr. Homer Folks, of New York City, whom the chairman introduced as "the greatst social engineer of modern times", gave a thoroughly practical as well as an epigrammatic talk on "Administrative Problems of Lay Directors". Mr. John H. Ellsworth, of New York City spoke on the vexatious "Financial and Publicity Problems". The various papers were followed with the keenest interest by the large audience, and were liberally discussed. It was plainly evident that the establishment of a forum for the discussion of views by lay directors will henceforth form an important feature of the Association's proceedings.

THE SECTION MEETINGS

Among the special sections, Dr. Francis Sage Bradley, of the Federal Children's Bureau, presided over the Round Table on Rural Problems. "Rural Obstetrics" by Dr. F. L. Adair, of Minneapolis; "Nutrition of the Rural Child", with Dr. Ethel M. Watters of San Francisco, covering the period of infancy, and Miss Mary E. Murphy, of Chicago, treating of the period of school life, were the first subjects discussed. County Health Centres were described by Dr. W. S. Rankin and Miss Rose M. Ehrenfeld, R. N., of Raleigh.

Dr. E. J. Huenekens, of Minneapolis, was prominent in the discussion that followed.

The Round Table Conference of Directors of Divisions of Child Hygiene was called to order on Friday morning by Dr. Ellen C. Potter, of Harrisburg. The program included (1) The Organization of State Divisions of Child Hygiene with Special Reference to Emphasis on the Budget," by Dr. Merrill E. Champion, of Boston; (2) The Relation of State and Municipal Child Welfare Activities to Private Physicians, by Dr. E. V. Brumbaugh, of Milwaukee; (3) Public Health Nursing in Relation to the Work of Child Hygiene Divisions by Margaret K. Stack, R. N., of Hartford; (4) Is a State or Municipal Official Prenatal Program Practicable, and if so, What Is Its Scope and Method?, by Dr. S. Josephine Baker, of New

York City, and Dr. Ethel M. Watters, of San Francisco. This, as usual, was one of the most spirited gatherings of the meeting.

A JOINT SESSION WITH THE N.O.P.H.N.

The Session on Nursing and Social Work on Saturday, November 5, was a joint session with the Child Welfare Section of the National Organization for Public Health Nursing. Miss Sara B. Place, of Chicago, was Chairman. The program included a paper on "Volunteer Workers in a Public Health Program with the Child of Pre-school Age", by Miss Isabelle Boyce, of Grand Rapids, with a full discussion, and a "Round Table on Records", presided over by Miss Anne A. Stevens, R. N., of New York City. The report of the Record Committee of the Child Welfare Section of N. O. P. H. N., was read by Miss Helen Boyd, R. N., of Bridgeport. The session met at an early hour in order to avoid the necessity for an afternoon session, so that those who wished might later attend an important conference at the Yale Bowl. Miss Anne Sutherland's paper closed the joint session with an analysis of "Teaching Methods and Equipment in Health Programs for the Child Under Six Years."

AT THE NEW HAVEN HOSPITAL

In the Medical Session on Saturday, at the New Haven Hospital, Dr. Edwards A. Park, presiding, Dr. F. L. Adair read his paper on "The Relation of Obstetrics to the Community", and Dr. Robert Osgood, of Boston, discussed "Is there any Evidence to Suggest that Poor Posture Bears any Causal Relation to Poor Health in Children?" Dr. Park's paper on "The Present Status of the Etiology of Rickets," was discussed by Dr. Lafayette B. Mendel, and two extremely interesting clinics under the direction of Dr. Park closed the program.

THE PUBLIC MEETING

The public meeting, held on Thursday evening at Sprague Memorial Hall, was attended not only by the members of the Association, but also by large numbers of the health workers and residents of New Haven.

President Henry L. K. Shaw presided, and on the stage were seated Dr. S. Josephine Baker, Dr. Samuel McC. Hammill, Dr. Philip Van Ingen, Mrs. William Lowell Putnam, all former Presidents of the Association, together with Professor Irving Fisher of Yale, one of the founders of the organization, and Miss Grace Abbott, the newly appointed Chief of the United States Children's Bureau.

President Shaw read a letter of welcome from Mayor David E. Fitzgerald of New Haven, and also letters from the incoming President of the Association, and from its first President, Dr. J. H. Mason Knox, both regretting that circumstances prevented their attendance at the meeting.

President James R. Angell welcomed the Association on behalf of Yale University in a graceful speech, and then Miss Grace Abbott, Chief of the Children's Bureau, who was the speaker of the evening, delivered her address, "Problems and Standards of Child Welfare". Miss Abbott's address made a splendid impression on the large audience. It will be found elsewhere in this issue.

TWO IMPORTANT MESSAGES

Even in the absence of the incoming President, Mr. Hoover, the words of his message sank deeply into the consciousness of all who attended the meeting and sustained applause greeted the paragraph in which he said: "The work which the American Child Hygiene Association has done and is doing is in my opinion of very far reaching importance, and it is hard to over-emphasize the beneficial results which will follow both directly and indirectly from the growing activities of this organization."

And no less cheering was the inspiring letter to President Shaw from the first President of the Association, Dr. Knox, who wrote from Paris, saying:

"It is a great disappointment to me, that in connection with my service in the American Red Cross in Europe, I shall be unable to attend the annual meeting of the American Child Hygiene Association.

"As its first President I am always intensely interested in the development of our Association, and have closely followed its fortunes since its organization at the meeting in New Haven twelve years ago. Our history has been one of constantly increasing growth and influence. When we consider how much has been done in America for the protection of child life since 1909 and realize that although we may not have been directly responsible for the inauguration of many specific activities, it is true that almost no important piece of work in this field has been undertaken in this interval in America upon which the advice of our office has not been sought, and in the furtherance of which we have not been helpful. In this period bureaus of child welfare have been started both in State and City Health Departments and hundreds of local volunteer organizations have been chartered to carry on some phase of the child health program. The results are manifest on all sides, notably the marked fall in infant mortality in all parts of the country.

"This is not a time for self-congratulation, nor for anything but a hurried and grateful glance behind at what has been accomplished, and a girding of the loins for further effort until the goal be reached, and all unnecessary morbidity and mortality in infancy and childhood be done away, and every new-born baby be given a chance for life and happiness.

"Very properly a number of years has been spent in securing proper support and in trying out various methods of work. This stage is now over and procedures have been approved wherever our metier has been well done. The next step would seem to be the actual demonstrations of results, carried out in such a way as to leave no doubt that child life can be conserved in any community which desires it sufficiently.

"I hope that the Mansfield, Ohio, program in which our Association is to take a leading part, may prove to be such a demonstration and that it may be followed by many others.

"Even among the unsettled conditions in some of the countries of central Europe we hope to reach every infant in several selected communities, believing that in this way we are making our most enduring contribution to the children of these nations.

"I trust that the annual meeting under your presidency may be a great success and clearly mark the progress made since the last meeting in New Haven, and that in the new year, under Mr. Hoover's direction, further strides forward may be taken and that our new President may realize that in showing how the lives and health of American children can be conserved, he may be making the most enduring contribution to the well-being of children throughout the world."

The members of the Association left the place of its birth, New Haven, proud of the record accomplished in the past year, expectant of even a better record in the forthcoming twelve months, and refreshed and gratified by their brief stay in proximity to the cloistered charm of an old and distinguished University set in the midst of what has become a busy industrial center.

Administrative Problems of Lay Directors of Voluntary Organizations

Homer Folks*

I HAVEN'T any paper, only a few notes put together on the train on the way up. The topic has to do with the problems of members of Boards of Managers of private organizations. For convenience I will number them:

Problem 1. Ought there to be such an organization? It is not at all difficult to start one,—perhaps it is too easy. They begin in a variety of ways. A field worker of some national organization drops into town to start things going, or a public spirited citizen reads of what is being done in some other locality and says why don't we have that kind of thing here. Or, once in a while, somebody sees in it a good chance to get public notice. The prospective member of such a board is asked by a friend to drop around that evening to consider organizing a society for the health of children. He does not know it, but probably the by-laws have already been written and a list of the names of the managers and executive committee is already in the pocket of the person giving the invitation; but the prospective victim does not need to assume that. This is the first problem,—to be sure that there is a job to be done. He is entitled to be "from Missouri",— the burden of proof is on those who propose a

**Stenographic report of an address delivered at the Twelfth Annual meeting of the American Child Hygiene Association.*

new organization. There is always a real job if the program is a general one for the health of children unless there is already such a society in existence. If the undertaking is to be of a limited and special character, it may not be at all necessary in that particular locality.

Problem 2. Having satisfied yourself in a general way that there is a real job to be done, and having decided to have an organization with its by-laws and its members, the next problem, logically considered, is that of defining your program, but as a matter of fact, you can not advantageously do this with any degree of confidence until you have previously solved another problem,—that of finding a director,—a responsible paid executive, who is to be on the job all the time and whose personal fortune, so to speak, will sink or swim with the success of this organization. You need, and need very seriously, the services of such a full-time man before you can make a sufficiently close survey to frame your detailed program. What a responsible job it is,—the finding of a director! I wish some kind of insurance could be devised to protect us against mistakes in choosing executive officers. Nearly everything depends upon him and how can one tell how well he is going to do. You can only be sure that you thoroughly understand what his education and training have been, whether his experience fits him for this job, whether he left his last job voluntarily or involuntarily, whether he has an open or a closed mind.

Problem 3. This is to formulate your program for the year. It means getting all the light you can from national, State or private organizations, if any, in the field of child health. It means getting all the light you can from the State Health Department and local health authorities, as to what is being done about child health in your locality. It means framing a real program, in the light of all these circumstances and in the light of all the pertinent information in regard to the concrete needs, situations and opportunities in your particular locality. It is pretty safe to say that a careful survey will show that these concrete situations are quite different from that which any member of the board would have presumed them to be.

Problem 4. Having gotten your society, your director, and your program, the next problem is to establish the principle of centralizing operations through the director and to hold him responsible for results. This does not mean at all that there shall not be active and responsible committees of the Board of Managers; it does mean that all these committees will function, when it comes to operating, through the director and will not themselves deal directly with subordinate members of the staff nor undertake concrete operations except in full harmony with the full program as laid down and practically as members of the staff, so

far as operating activities are concerned. This does not mean that the director is to be "the whole show." It simply means that there is to be order, harmony, efficiency, no overlapping, nothing forgotten, and a full knowledge at headquarters of all that is going on.

Problem 5. Having gotten the society, the director, and a program and having established the principle of responsible executive direction, the next task is that of being sure that the members of the board of directors are kept adequately informed, that they have the data on which to base a sound judgment as to how well the program is being carried out, and on which to base admonitions to the director and even to remove him, if he proves incompetent or unsuitable. This means the establishment of a system of reports to the director from all members of his staff of all the operations that are going on and, on his part, a system of submitting well proportioned and complete reports to all the members of the board of managers. This is just the point at which many members of most boards of managers seem to me to fail. If the principle of centralization of responsibility is adopted, they feel "out of it." They want to be doing something, but they fail to do the one thing needed above all others, namely,— to be sure that they know what is going on. It is so much less interesting to keep informed about the whole range of the work, than it is to actually do some one minor thing. If I could have a megaphone large enough to carry a message to every member of every board of directors of every voluntary child health organization, and could deliver only one message, it would be this:— "For the love of whatever you consider highest and most holy, do, please, read what is sent to you, listen to what is said, and look at what is shown." The managers' job is, fundamentally to think, and to decide on underlying questions of policy, program, and personnel, to review and to judge. Most of us hate above all things to think but as managers, that is our first duty. We have only five senses. We can not learn very much about what our society is doing from the sense of touch, or that of smell, we can take in something by hearing, but time is so limited. We can take in most of all by reading carefully prepared statements, and if such are not sent to us, we should demand them and then study them. As managers we should realize that they also serve, and oftimes serve best, who only sit and think.

Problem 6. To get rid of useless and unsuitable members of the Board, a task requiring a tremendous amount of tact and a colossal amount of nerve. In picking out any considerable number of members of any board, you are almost certain to pick one or more "lemons." Nothing is a greater drawback to the development of a piece of important work than the retention of troublesome, useless, uninterested, objecting, unsympathetic

members; but it is almost unbelievably difficult to leave them behind. Nevertheless, it is a part of our duties, as members of boards, to remember that the highest obligation is to the people of the community for whose benefit the organization was established, and that anything standing in the way of securing that result must be removed.

Problem 7. To find out how each member of the board, besides carrying his share of the moral responsibility, and besides thinking and voting on questions of policy and program, can also contribute some actual work. As a matter of fact, such boards are made up of representatives of many walks of life. Each member can contribute something. The real estate member can help in getting offices in the right place on reasonable terms and little by little he may come to see what a tremendous factor housing and rentals are in child health. The lawyer can do his part, the editor can be of tremendous value in interpreting the undertaking in terms which the ordinary citizen will understand. The politician, if really interested, can be almost more useful than anybody else. He can smooth away many difficulties which seem insuperable; in so far as cooperation with the public authorities is concerned, he can work miracles. The physicians, of course, can help enormously at every stage, and the women, whether they belong to the professions or are simply expressing their natural interest in the welfare of children, will always constitute more than half of the total functioning management of the enterprise.

Problem 8. To check up at the end of the year, take stock, see how far you have gotten. It is astonishing how frequently the entire original program is little by little pushed aside and then forgotten in the course of the first year. The chances are that if, at the first annual meeting, any member of the board of managers should call for the reading of the original program, the director could not find it. It is embalmed in the minutes which perhaps already have been placed in cold storage. Not that the original program should be rigorously followed, but that the organization should always know when and for what reasons it is departing from it, and at the end of the year should be able to form a sound judgment in the formulation of a program for the coming year.

If all these problems are clearly seen as they arise by the members of the Board of Managers and by the Directors, if they are squarely faced and a serious effort is made to deal with them adequately, you may be sure that by the end of the year a very substantial contribution will have been made to child welfare in that community and the foundations will have been laid for an increasingly influential and intensive program in which the entire community would sooner or later become involved for saving its children from needless sickness and premature death.

Child Welfare Problems and Standards*

Grace Abbott, Chief of the Children's Bureau, Department of Labor, Washington, D. C.

AT THE second annual meeting of the Association for the Prevention of Infant Mortality Miss Lathrop spoke on the importance of birth registration in any program for the prevention of infant mortality. On that evening she reported that the Bureau had had thirty-nine days of life. My life as chief of the Bureau is very little longer and, with your permission, I should like to say something about the organization of the bureau, before I take up the subject on which I have been asked to speak tonight.

As you doubtless know, the statute creating the Bureau directs it to report on all the problems of child life, mentioning especially "infant mortality, the birth rate, orphanage, juvenile courts, desertion, dangerous occupations, accidents and diseases of children, employment and legislation affecting children in the several states and territories."

It is at once apparent that to follow the directions laid down by Congress experts in widely separated, although related, fields are necessary. The Bureau has for some years been organized in five divisions as follows: A Hygiene Division, an Industrial Division, a Social Service Division, which is especially concerned with the problems connected with dependent, neglected and defective children, a Statistical and an Editorial Division.

This Association is particularly interested in the problems which are before the Hygiene Division, and I should like therefore to speak especially of it. Its directors have always been physicians especially experienced in the field of child hygiene; the other physicians and the public health nurses who make up the staff of the division are also specialists in this field. The routine work of the division has been not only the making of investigations in some of the several fields of child hygiene, conducting health demonstrations at the request of municipal or state health departments, rewriting in popular form for mothers the scientific findings of specialists, but it also serves in an advisory capacity to the other Divisions of the Bureau in all problems relating to hygiene.

Valuable as the work of its own staff has been, I want to take this occasion to acknowledge the help which the Bureau has had from physicians not on the Bureau's staff who have served in an advisory capacity to the Bureau, helping in the

Address at the Twelfth Annual Meeting of the American Child Hygiene Association, New Haven, November 2, 1921

formulation of its policies as well as on technical questions connected with its reports. It will mean much to me if I can count on a continuation of the very generous help which the Bureau has had from physicians. The bureau offers a means of passing on to hundreds of thousands of mothers information they seek with reference to the care of their children. I feel therefore that we are warranted in asking for advice and criticism of the plans and work of the Hygiene Division of the Bureau.

I have, however, been asked to discuss not the Children's Bureau but Problems and Standards in Child Welfare.

In a country as large as the United States, in which there is such decentralization of control—not only that very fundamental division as between the federal and the state governments, but between the state and the local units also—it is particularly important there should be discussion and agreement among leading experts in the field. Goals which they are, in the light of information now available, striving to reach should be defined, a common nomenclature and in certain fields a uniform system of record keeping, so that results secured in different parts of the country may be generally comparable, need to be agreed upon.

The series of Conferences on Standards of Child Welfare held under the auspices of the Children's Bureau in the spring of 1919 had these general objects in view. The standards adopted at those Conferences represented, I think it may be said, the judgment of acknowledged scientists and practical workers in the various fields covered by the report as to what should be reasonably possible of attainment in the United States. All of the reports emphasize the necessity of further research in order that the standards adopted may be modified or radically changed as discoveries in the medical and the social sciences indicate.

I am not going to speak tonight of the standards which were adopted by the section on The Health of Children and Mothers at that Conference. As your Association has extended its scope to include the problems of the adolescent child, I want to discuss briefly one problem connected with the health of this last group of children whom you have added to your number. It is a field in which research and interest is greatly needed—the protection of the health of working children.

The first efforts to accomplish this end by legislative enactment were the early laws giving to factory inspectors power to require a physical examination of a child found at work who appeared to be physically unfit for employment. Illinois, Michigan, Minnesota, New Jersey and New York were among the States which passed laws of this general type in the nineties. A number of these laws are still on

the statute books, and a few states have, in recent years, passed similar ones. The factory inspector, however, visits a plant perhaps once or twice a year and inspects for the health, safety and comfort of adults, the hours of work of women as well as the employment of children, and it is therefore not surprising that experience showed that the inspectors did not frequently raise the question as to whether the physical appearance of an individual child suggested that he should not be employed. Moreover, once given a permit to work and already employed for weeks or months, the removal of the child on the order of the physician was almost sure to arouse serious opposition, which might have been avoided if employment had been prevented.

Profiting by this experiment, the next legislative advance was to authorize officers issuing work permits to require children who appeared to them as not fit physically for employment to be examined by a physician before the work permit was issued. This still left the selection of the children who were to be examined to someone without training for that work.

A mandatory requirement of a physical examination for every child at the time he applies for an employment certificate, now found in the laws of 19 States was an obvious next step.

In Delaware, Illinois, Maryland and Pennsylvania the law specifically requires a child to be re-examined by the physician whenever he changes from one employer to another. Although the express requirement of a re-examination when changing from one employer to another is not found in the laws of any of the 14 remaining States which make the first examination mandatory, there is reasonable ground for believing this to be implied wherever the law, in addition to requiring a child to be physically fit for the work he intends to do before he can obtain an employment certificate, makes him secure a new promise of employment and a new certificate for each new employer.

No State has as yet advanced to the next stage—the examination of every working child at regular intervals during the years when he is peculiarly susceptible to the strains of industry in order to determine whether the work at which he is engaged is injuring him or interfering with his growth.

The best of the present mandatory laws require that a child must be of normal development, in sound health, and physically qualified for the particular work he is to do; that these facts must be established by an examination made by a physician or physicians officially designated for this purpose. In order that the physician may judge the child's fitness for his intended work, the child is required to bring a promise of employment signed by the prospective employer

and stating the occupation in which he is to be engaged. In these States the law contemplates that no child shall go to work until a physician, usually from the public school system or the board of health, but in some cases one connected with the department enforcing the child-labor laws, has given his approval.

How valuable such a law will prove to the individual child will depend, (1) on the standard adopted by the examining physicians and (2) whether the physicians' recommendations are followed by the permit issuing officer, and (3) whether the factory inspector is aiding by enforcing the law requiring employers to secure the permits. It is the first that we are immediately concerned with tonight. In some localities a routine examination with no certificates refused or issuance postponed pending correction of defects, merely added to the expense of administration without giving any protection to the child. But the physician who was prepared to give all the protection possible under the law finds a lack of definite standards a serious difficulty. "Sound health" and "normal development" are undefined, and "physical fitness" for a specific occupation can not be determined without precise information as to occupations and their effect on the growth of the body and on the health of the child.

In this field, as in so many others the pioneer work was done by the Child Hygiene Division of New York City, under Dr. Josephine Baker's direction. But the standards worked out for New York City were not generally known and laws passed subsequent to the New York one had some new improvements.

At the Children's Bureau Conference on Standards of Child Welfare (May and June, 1919) when this general subject was under discussion, Dr. Emma Appel, who was working very hard to give the children of Chicago the full benefit of the Illinois law called attention to the fact that refusal to grant a permit because of the physical condition of the child is sometimes appealed to the superintendent of schools, contested by an alderman, and sometimes carried to the courts by the parents. In these cases she and others present agreed that a generally accepted standard would be of value not only to the doctor in reaching decisions, but insure the support of the administrative department and strengthen a case if brought before the courts.

Acting on a proposal which grew out of this discussion a committee of physicians, most of whom are at work on this special problem, was appointed by the Bureau to see if certain standards could not be agreed upon. This committee made a preliminary report submitting a tentative record form which was sent for criticism and suggestions to State labor officials, local certificate issuing officers, examining

physicians and others interested in physical standards for working children. After this record form had been tried out in several cities the preliminary report was revised and in this form has been printed by the Bureau.*

In the so-called general recommendations which the committee made it called attention to the "need of study by local administrative and medical officers of occupations in which children are employed and of their effect upon health," and the "need of authoritative scientific investigation as to the effect of different kinds of work upon the health and physique of the adolescent child. The committee rightly insisted that "occupations in which children are likely to be employed should be made the subject of special study for the purpose of ascertaining their physical requirements and their effect upon the health and development of the growing children," and that to do this "the examining physician should be authorized and required to visit periodically industrial establishments and to familiarize himself with conditions of employment and with the various health hazards of industry."[1]

While pointing out the necessity of further study, the committee did agree upon certain tentative minimum standards for children entering and working in industry.[2] What may be accepted as "normal development" was agreed upon. In connection with the enforcement of the "sound health" and "physical fitness" standards the recommendations of the committee contemplate three possible decisions by the examining physician: (1) refusal of a work permit, which means in States in which the child labor and compulsory attendance laws are consistent that the child returns to school, in most states until he is 16 years of age; (2) refusal of permit until a defect has been corrected; and (3) granting a provisional certificate for a period not to exceed three months when treatment has been started and not been completed.

Children having provisional cer-

*The membership of the Committee was as follows.
George P. Barth, M. D., Director of School Hygiene, City Health Department, Milwaukee, Wis., chairman.
Emma M. Appel, M. D., Employment Certificate Department, Chicago Board of Education.
S. Josephine Baker, M. D., Chief, Bureau of Child Hygiene, Department of Health, New York City.
Taliaferro Clark, M. D., representing the United States Public Health Service.
C. Ward Crampton, M. D., Dean, Normal School of Physical Education, Battle Creek, Mich.
D. L. Edsall, M. D., Dean, Harvard Medical School.
George W. Goler, Health Officer, Rochester, N. Y.
Harry Linethal, M. D., Industrial Clinic, Massachusetts General Hospital, Boston, Mass.
H. H. Mitchell, M. D., representing the National Child Labor Committee.
Anna E. Rude, M. D., Director, Hygiene Division, United States Children's Bureau.
Thomas B. Wood, M. D., Chairman of Committee on Health Problems and Education, Columbia University.
Miss E. N. Matthews, Director of the Industrial Division of the Children's Bureau, has acted as secretary to the committe.

1The Committee report giving details will be furnished by the Children's Bureau upon request.

2The revised minimum standards adopted by the committee January, 1920, appeared in full in Mother and Child March, 1921.

tificates are to be re-examined at the expiration of the period for which the certificate was granted and before a final certificate is issued. A recommended record card for the examination was also agreed upon.

In several states the form or a modification of it has been recommended by the state supervisory officers to local official. In Indiana a conference of school physicians, the State Industrial Board and the State Board of Health, has adopted a form which meets the requirements of the Indiana law and the recommendations of the committee. Interest on the part of industrial physicians has been evidenced.

It is important that the form recommended be tried, criticised and then revised in the light of experience. Some sacrifice of individual opinion as to classification will always be necessary, but uniformity in the record is so important if comparisons are to be made and the full national value of the examination is to be realized that it seems little to ask. The Bureau and the committee of doctors is eager to incorporate in a revised report improvements based on the experience of a considerable number who are actually using the forms.

While I hope that the physicians and the administrative officers who are responsible for the enforcement of the laws for the protection of the health of working children will have the interest and support of this association, I am particularly eager that your attention be given to the supplementary research which must be made to enable them to make correct decisions as to particular occupations for which an individual child should or should not be certified.

At the Children's Bureau Conference on Minimum Standards of Child Welfare, held at the close of Children's Year activities in 1919, Dr. Edsall pointed out in a discussion of the protection of the health of working children and young persons that "children are peculiarly prone to the effects of general physical strain, and to the effect of postural strains—a fact sometimes overlooked in regulations."

Our protective legislation has, generally speaking, taken the form of prohibiting the employment of children in certain hazardous occupations—usually an enumerated list of machines and processes. Dr. Edsall finds that while very few children are still injured in processes which can be classed as highly dangerous occupations, there are many who are greatly injured by the fact that, suffering from some small or serious physical defect, they have gone into occupations unsuitable for them. Accidents are not so reported as to make it possible to say what the accident rate among children is in the various occupations in which they are employed. While hazardous work must still be done, it does not have to be done by children too

young to understand the hazard. Prohibition of their employment in such occupations and discouraging their employment through provisions in the compensation laws for triple compensation are therefore necessary. The findings of Dr. Edsall indicate, however, that these alone are not enough.

During the past year the Bureau has completed two experimental studies of child welfare in typical rural localities, one in selected sugar-beet-raising areas of Colorado and Michigan, and another in a cotton-growing section of Texas. On the theory that employment in agricultural work was healthful it has been unregulated. In the study of the sugar-beet-raising area of Colorado the Bureau found that children worked at very early ages, more than half the child workers included in the study were between the ages of 9 and 12 years, inclusive, and the average age was 11 years. These young children thinned out the small plants in the spring, hoed, pulled up the beets when grown, and finally "topped" them. "Pulling" requires considerable physical effort, for the matured beets weigh from 2 to 2 3-4 and sometimes as much as 8 or 9 pounds; in "topping" a certain amount of danger is involved, especially for the younger children, as the work is done with a long, sharp knife hooked at the end. Physically, however, the most harmful feature of the work probably lies in the long continued strain. From 64 to 85 per cent of the children (the proportion varying with different processes) worked 9 hours or more per day, but the working-day was sometimes 13 or 14 hours. The continued stooping in kneeling and crouching positions when "thinning" and the lifting and handling of heavy weights in "pulling" and "topping" affects, the evidence indicates, the posture and outline of the growing child's body. Seventy per cent of more than 1,000 children employed in the beet-field who were examined in connection with this study by the Hygiene Division of the Bureau had postural deformities and malpositions apparently due to strain. Winged scapulae and flat foot were the most numerous defects noted. Thus 66.1 per cent of the entire group show winged scapulae, indicating that in two children out of every three the muscles of the back were unable to sustain the weights they were called upon to bear during the period of growth. In this postural deformity which was excessive in these cases the shoulder blades lie obliquely on the sides of the chest, protruding behind, the shoulders are rounded, the chest dragged downward and there is interference with free action in breathing.

This 66.1 having winged scapulae may be compared with 42 per cent among well children in an eastern survey and 65 per cent among a group of children applying for clinical care.

Flat foot was noted 221 times or among 21.6 per cent of the children examined. Flat foot percentage among well children is quoted at 6 per cent and among dispensary cases (children), 9 per cent, so that this high rate among the children employed in the beet fields appears to be the result of the strain upon immature muscles. More examinations in this and other occupations of older as well as younger children are greatly needed.

I shall not take further time for the discussion of the protection of the health of the working child for I want very much to call attention, in the few minutes of my time that remain, to the special needs of this particular time. I do not need to remind anyone that it has been a year of serious industrial depression and consequent unemployment and that whether the peak has or has not been passed we cannot expect immediate recovery. It is also unnecessary to point out that an adequate family income, wholesome and pleasant housing and living conditions are fundamentals to the realization of any child welfare program.

During the past year income and savings have entirely disappeared in many families and have been seriously reduced in a larger number. We are therefore face to face with a situation which may mean that standards of child care that have been slowly raised during the last decade will be or already have been distressingly lowered. At this time the obligation of this Association and of its constituent membership is peculiarly heavy. Instead of lower budgets, higher ones are needed by all kinds of child caring agencies. We shall all have failed the children in this crisis unless we are able to make their special needs understood by the general public and more specifically by the contributing public and I mean to include in that term legislative bodies that control appropriations as well as individuals by whose generosity so much has been accomplished for children in the past.

New Maternity and Infancy Law

The Sheppard-Towner Bill, S. 1039, for the promotion of the welfare of maternity and infancy, was signed by the President on November 23, 1921.

The principal changes made in this bill are as follows: The appropriation is now limited to five years, and the sum of $10,000 for the first year, and $5,000 annually thereafter, is given outright to each state. A Board of Maternity and Infant Hygiene with definite duties is created instead of an advisory committee. The amount for administrative expenses for the Children's Bureau is increased from three to five per cent of the appropriation. The bill further provides for appeal to the President if certification by the board is withheld.

(*Bi-weekly Legislative Statement No.* 16, *National Health Council, Washington, D. C.*)

Health Habits in the Kindergarten

Julia Wade Abbot, Bureau of Education,
Department of the Interior, Washington D. C.

IN a recent article by Dr. Arnold Gesell on kindergarten control of school entrance, it was stated that the kindergarten occupies a strategic position in the child welfare campaign: its outer door opens into the homes of the people and its inner door into the elementary school. It is linked up with the pre-school period, a most important time in the life and education of the young child.

What then is the responsibility of the kindergarten to the pre-school child, who is passing through the most important, and perhaps most neglected phase of its education? A great mistake in dealing with children is to treat them—not as they are—but as disembodied intellects. Little children must have both a mental and a physical examination and the kindergarten teacher should see to it that records are kept of the child's development, and this development should be the only true index of the child's progress. The type of record card used is often very misleading and we must use a card that really does give the information we want about the child. Miss Davis, of Duluth, tells a story about a little girl who brought home her card and on it was recorded the statement, "Language: 73." The child exclaimed, "If I had known what that meant I could have talked more than 73." Lately not only have we been concerned in keeping records of the child's weight and height, but also of his social habits and attitudes, which are an important index of his total development. I may here remark that though the kindergarten has often been thought queer and foolish, we have been allowed to do many things we wanted to on that account. The health habits of the child can be registered on the card and will serve as an index of an intelligent response to the right sort of environment. In this connection I would like to give a warning against burdening the child with the effort to meet conditions for which he is not responsible. In one of our large cities the children in a fourth grade were being marked by rows according to the number of "health chores" they reported having done at home. One little boy had spoiled the record of his row by remaining seated for a whole week when the other children stood in answer to the question, "How many of you have opened the windows in the room where you sleep at night?" Imagine the attitude of the other children in the row and the persecution

he probably endured at recess and on the way home from school. One day a sympathetic supervisor was in the room and she drew the little lad aside and gained his confidence. With pent-up anguish he said, "Teacher, I haven't any windows in my room, but I open the window in the next room and the door in between, can that count?" And she quickly replied, "You shall have two marks, one for opening the door and another for the window."

Because of situations of this kind, I am skeptical as to the value of questioning the children in class about what they do or what the family does at home. It is apt to put a premium on lying. I know in my own family my little niece said: "I always try to dress myself on Sunday morning, so that I can tell the Sunday School teacher how much I help mother." Habits should be a natural response to the right environment, not to studied questioning.

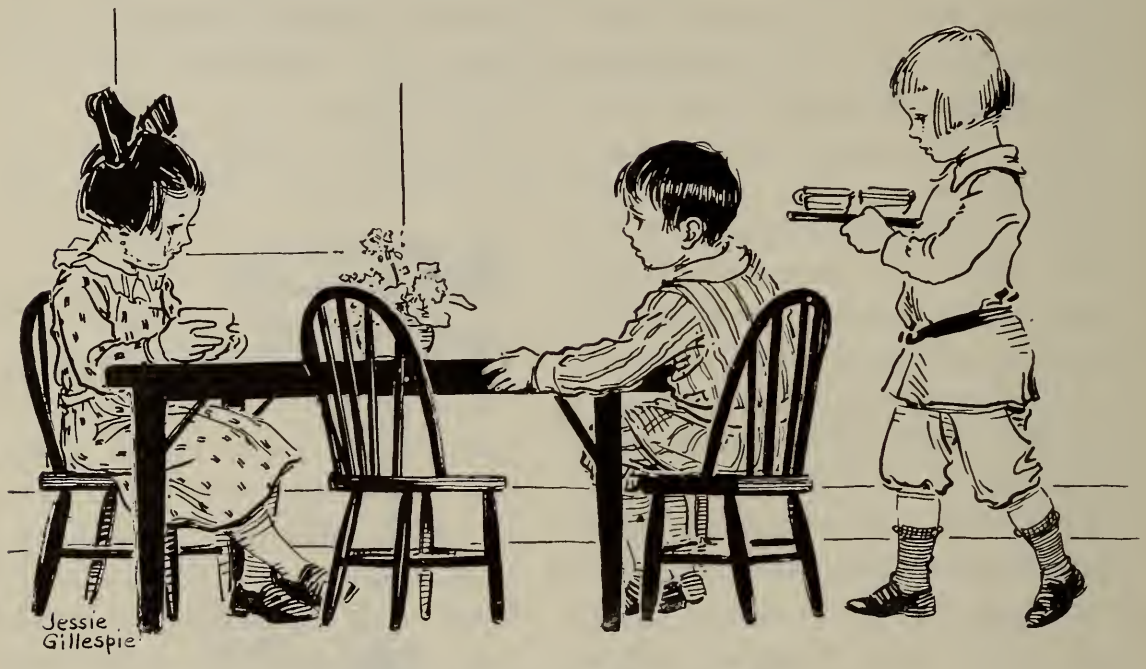
In the school life natural situations arise which give an emphasis to basic habits which will be of value to the child. The large sunny rooms, clean floor, keeping of pets, serving of a wholesome lunch and cleaning up and putting away things afterwards call forth a joyous response from the children, which results in an instinctive attitude of harmony and order. The teacher is responsible for right conditions in regard to light and ventilation, and should have the children spend at least thirty minutes out of doors every morning. One little child said to me, "Teacher, I love to wash dishes here, but I hate to do it at home." This is often the case, the children showing enthusiasm for "chores" in school which they often hate to do at home. It would be a good thing, I think, if mothers and teachers could sometimes change places, so that each could understand the contrast in the situations in school and at home.

The spirit of class feeling is a big factor in the discipline of the

What a Big Boy Am I?

child. I know one summer I tried to take care of three small children. I was up against it. As fast as I tried to put their clothes on they threw them out of the window. The child recognizes social sanction that is given habits that are useful and constructive. Often the child learns to drink milk, with the other children at the lunch period, although he may refuse to do so at home. You hear: "Ain't you glad, teacher, Tony's drank his milk." And teacher is glad. Children are little imitators, and perhaps they see father spit on the floor at home. Willie spits on the floor at school and the teacher shows her disgust and disapproval while all the other little Pharisees who did not spit on the floor side with teacher and show disgust, too. The fact that the delinquent has to go and get a little pail and some sapolio and scrub the floor by himself, is far more effective at this age than a lecture on germs; for though it often is lots of fun to scrub the floor together it is quite a different matter to do it under the disapproving eyes of teacher and of the members of the class.

The school lunch gives the teacher an opportunity to show the mother how much better it is for the child to bring his pennies for milk and crackers than to spend them on all-day suckers. We can teach the children that milk makes them strong and that what goes into the mouth has an effect on health and growth. Even many mothers are so ignorant that they do not understand this simple fact.



"The others drink milk—so will I"

In the play of the kindergarten many habits of decency and order can be taught through dramatization; the care of dolls, pretend

shopping, and keeping store, which gives a chance for arrangement of possessions. All this busy, natural environment makes for the mental health of the child and gives an atmosphere of joy without overstimulation.

I want to tell the kindergarten experience of a little boy of Austrian parentage, named Emil. This child came to school repeatedly in such a filthy condition that the teacher decided to take him home and insist on his mother's changing his clothes and sending him back clean. When she got to the house the only persons there were a mother and young uncle, who spoke English poorly and assumed a very antagonistic attitude. This had an immediate effect on Emil. He worked himself up into a passion and flew at the teacher and bit her on the wrist. The teacher kept quite calm. She mastered the boy and held her ground, insisting that the child's clothes must be changed before he return to school. Evidently her quiet impersonal attitude had its effect, for the young uncle came round to her side and finally the mother was won over, and they cleaned the child up, changed his clothes, and let him go back with the teacher. This storm cleared the air, because after that Emil became noticeably cleaner and more sociable. One day when the children were making toy aeroplanes one boy called out, "Why, Emil's is the best of the lot." Approbation had its effect, and Emil for the first time really became a member of the group. The mother was brought into a friendly attitude and came to visit the teacher. She confided that when the child grew up she wanted him to be a musician, because he had a good ear and a clear little voice. This shows that the teacher should visit the home and try and establish a good understanding with the family. The nurse and the social visitor are more or less associated with catastrophe in the mind of the family, but the teacher has an easy and natural introduction in speaking to the mother of the child's progress. There are always neglected children in every class, and it is the teacher's duty to see that they learn to use their handkerchiefs, to have good habits in regard to going to the toilet. These things need the mother's cooperation.

What a lack of proper environment there is for this type of training. What overcrowding, what lack of beauty in the schools in which we force little children to pass many hours of the day. When we look at their surroundings we can agree with the writer who said that our schools were institutions for maiming human beings. How much of this remark is true? How closely do we follow for our children the example of those who cared for the child who "grew and waxed strong in spirit and was filled with wisdom."

MOTHER AND CHILD
A Magazine Concerned With Their Health

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DECEMBER, 1921

The New Haven Meeting

The Twelfth Annual Meeting has gone into history as a great success. Two notable features of this year's gathering were the sessions devoted to "Problems of Lay Directors" and the attention given to papers on educational psychology as applied to health teaching. These were new departures, although in diverse fields. Both features by the interest they evoked, indicated the excellent judgment of the Chairman of the Committee on Program, Dr. Richard M. Smith, in making this diversion from conventional subjects.

The decision of the Honorable Herbert Hoover, Secretary of Commerce, to accept the active duties of the Presidency of this Association during 1921 and 1922, was a source of the greatest gratification to all who attended the meeting.

The progress of the Association in the past year was gratifying and the report of the General Director, Dr. Richard Bolt, showed us not only the remarkable technical achievements of the organization during the past year, but inferentially, at least, the necessity for girding up our loins and securing many new members to help maintain this progress. It is evident that our situation is like that of a business enterprise with limited capital and more orders than it can fulfil. Our capital is largely our membership list, and if each member will secure only one other member we can double this capital over night. This is a plan worth not only of thinking on but of acting on. It is far from one of the least important lessons of a most important Annual Meeting. JOHN FOOTE.

Daylight Saving and the Health of Children

In Walter Pater's remarkable novelette, "Emerald Uthwart", which breathes the charm of English country life, we read that "it was a rule, sanitary, almost medical, never to rouse the children". How essential this time-honored custom is to the conservative routine of English life we are reminded in an article by Dr. G. W. N. Joseph, Medical Officer of Health of the County Borough of Warrington, which considers the effect of the Daylight Savings Act

on the health of school children.* Reliable statistics as to this matter were difficult to obtain and consideration of the question is further obscured by the changed social conditions of the English working class since the Act went into operation. Better wages and shorter working days, with the advantage that the household is not aroused as early as formerly, have had their beneficent effects upon the nutrition and general well being of the sleeping child; and furthermore, the writer finds that in the Warrington area, "both in winter and summer, the majority of children go to bed when their parents do." Families now commonly take their children to places of entertainment, and on the other hand, the earlier closing of public houses sends the family to bed at an earlier hour. But apart from the operation of the Act itself, it has always been found that there is more fatigue in the summer than in the darker months, and in this the later bed hours, the light evenings, the noise and excitement of playing in the streets have their part. Bearing in mind Stevenson's observation that the English children are more physically active, "fonder of eating", "younger for their age", than those of the more imaginative races, this is what might be expected. The marked improvement in physique of the younger generation everywhere is a matter of common observation. The shrill-voiced urchin, with pipe-stem legs, who figures in Henry James' comedy of "Daisy Miller", is disappearing, and the essentially muscular limbs of young American girls were noted by Arnold Bennett as evidence of athletic habits. Doctor Joseph sees no reason for changing school hours from nine to ten A. M., but in the interest of children of inferior habit of body, he cautions against putting the clock forward two hours instead of one, and proposes the following to prevent any injurious effects of the Act:

1. Instruction of parents by leaflets, press notices, and so forth, warning them of the necessity for securing an adequate amount of sleep for children, the necessity for darkened, well-ventilated sleeping accommodations, and so forth.

2. By-laws prohibiting the attendance of children of school age at places of amusement after nine P. M. (that is, after the first performance.)

3. Stopping of unnecessary street noises (such as those caused by children playing, after a certain hour), if necessary by police action, or even prohibition of playing in the streets after nine P. M.

Beset as we are with multifarious laws, rules and regulations, this seems a large contract, and as our author affirms, the main responsibility for the child's welfare in this regard lies primarily with the parents. FIELDING H. GARRISON.

Joseph: Medical Officer, XXVI., No. 12, p. 129. September 17, 1921.

The Day's Work

Reports of Affiliated Societies

SUSTAINED enthusiasm and increasingly productive efforts mark the reports for 1920-21 sent in by the Affiliated Societies. These reports are to be printed in full in the Transactions of the American Child Hygiene Association, but the following excerpts indicate lines of departure made during the past year, or emphasize the need of carrying on established practices.

More and more the organizations are availing themselves of the invaluable assistance of lay workers.

The Woman's Auxiliary Board of the Chicago Infant Welfare Society is a volunteer organization of forty-two women. It raises over $50,000 a year toward the support of the Society and, through the development of centers, it has interested many thousands of Chicago women in the importance of child saving work.

The Children's Lunch Committee of St. Louis has two hundred volunteers who carry on the work of serving lunch at cost to the children in eight of the public schools of the city.

The Board of Health of Reading, Pennsylvania, has placed its recently created Child Welfare Department under the supervision of the Visiting Nurse Association, which now has charge of all the baby welfare work in the city. The report of the Visiting Nurse Association states than since they have been visiting all the new-born babies whose births are registered, the mortality of children under one year has been reduced by one half.

The Child Welfare Association and the City Board of Health of New Orleans are also trying to work out some system of cooperation whereby the Child Welfare Association will carry the major part of the nursing work, and the City Board of Health will supply physicians and sanitary inspectors. "As a beginning, the Board of Health has appointed a pediatrician to visit all newly born infants delivered by midwives. The Child Welfare Association is to supply the supplementary nursing care. It is hoped that this work will ultimately lead to the proper training and supervision of midwives, who deliver approximately sixty per cent of the babies in New Orleans. * * * * Under the Child Welfare Association, children of pre-school age receive a periodical medical examination every three months, and are referred to local hospitals or family physicians for corrective work. These children are seen by the physician at the end of the feeding conference for babies. During the year 1920, only 4636 infants under one year of age were supervised, as against 9871 children between one and five years of age."

The Division of Child Hygiene of the Providence Health Department under the superintendence of Dr. Ellen A. Stone, reports that in Providence the midwives are licensed by the State Board of Health and are supervised by the Division of Child Hygiene of the City Board of Health. All babies delivered by midwives come under the care of the District Nursing Association after they are a month old.

The New York Diet Kitchen Association is working in certain definitely prescribed districts where it now has "health stations", in spite of its old Diet Kitchen title. Miss Daniels says that it is not only carrying on its pre and post-natal work, but that it is also conducting health classes for eighteen hundred children of from two to six years of age. Moreover, the Association has extended its scope to include family health work, which is done in its Diagnostic Clinic for fathers and mothers, opened about two years ago in one of the Association Centers. "While this is not directly a part of the child welfare work, it has had two important results in that connection. First, a keener interest in health matters generally has been aroused so that the children are more readily brought to the Centers, and second, parents whose own health has improved through the aid of the doctors and nurses are not only more willing but more able to cooperate in carrying out the treatments or measures prescribed to put their children in good condition. These results have been so evident that if finances would permit similar clinics would be established in all the Association Centers. The work of the nutritionist is conducted as a part of the general care and supervision of the children of pre-school age. Her notes have their place on the record cards, and she works in close cooperation with the doctors and nurses in the correction of the defects found at the initial examination as far as they relate to nutrition and general health. In addition to her activities at the Centers and in the homes with the undernourished children, the nutrition worker devotes much time in assisting the mothers to teach their little children proper health habits, and correcting bad habits already formed by the older children, while a supervision of budgets and lessons in family hygiene are included in her duties."

PRENATAL CARE

The Maternity Center Association of New York City cites convincing figures which show the saving of life that results from proper prenatal care. "During 1920, in Manhattan, among the mothers supervised by this Association, one mother died for every five hundred babies born, one out of every fifty-one babies born died under one month of age, and only one out of every forty-two babies was born dead; whereas, among the mothers to whom pre-

natal care was not given, one mother died for every two hundred and five babies born, one out of every twenty-six babies born died under one month, and one out of every twenty-one babies was born dead. The splendid achievement of the Maternity Center Association was accomplished through its twenty-five maternity centers which cared for eleven thousand mothers and their babies. The Association, through these centers, provides medical supervision and nursing care throughout pregnancy to every expectant mother who can be reached and who is not already receiving medical and nursing care. Each mother is taught how to prepare for the new baby. Through the cooperation of doctors, hospitals, midwives and existing organizations the best possible arrangements are made for the mother's care at the time of her baby's birth, and during the following month. The Association maintains a clearing house at its headquarters, to which hospitals, individuals, and organizations report all maternity patients in order to prevent duplication in maternity work; and it acts as an educational agency for the entire country in popularizing the need for prenatal care and in demonstrating the possibilities of life-saving through intensive prenatal work."

The Toronto Department of Public Health seeks to educate the public in the value of proper prenatal care by conducting special neighborhood clinics. In 1920, 1,811 prenatal cases were supervised at the nine weekly clinics which are under the direction of a physician with the assistance of a public health nurse.

CARE OF BABIES

The Infant Welfare Department of the Scottish Rite Masons Consistory of Duluth consider their most significant piece of work that of educating a larger number of parents to a realization of the importance of breast feeding, and it is gratifying that 1920 shows a "marked increase in clinical attendance and also in the number of breast-fed babies."

The Visiting Nurse Association of Reading supervises all of the Baby Welfare Work of that city. Eight Baby Welfare Clinics are held in public school houses after school sessions are over. The Association also maintains a Babies' Fresh Air Home for sick babies, paying special attention to feeding cases. The Home is situated on the Reading Hospital grounds and is open during the four summer months.

The Babies' Milk Fund Association of Cincinnati follows up every baby and older child upon discharge from the wards of the Cincinnati General Hospital. Each child is seen thereafter in some one of the thirteen weekly clinics or conferences conducted by the Association.

THE PRE-SCHOOL CHILD COMES INTO HIS OWN

The Association of Day Nurseries of New York City comments in its report on "the deplorable neglect of the pre-school age child in our city, as a whole, which has led to the establishment by various agencies during the year of several clinics that are giving this group of children from two to six years the same attention that infants have had in milk stations, diet kitchens, and baby clinics. There are more than 377,000 children in our city between the ages of two and six years. Of this number 3,500 only are being supervised by the new clinics with a full medical record on file. Of the number of the same age in the day nurseries, about 4,000, comparatively few can furnish a full medical record according to the standard of the clinics. A new history and medical form has been devised by the various child welfare agencies, and the adoption of the same by the day nurseries should be considered.—To allow a child to enter public school from a day nursery with imperfect teeth, diseased tonsils, adenoids, under weight or in any way below par physically, should not be tolerated. Any child who has not been a sufficient length of time in the nursery to gain a normal condition, should be retained, receive special food and attention until he is physically fit. To say that the children have a hot noonday meal, may signify very little. Do they have the variety in proper combinations and quantity suitable for each age, to assure their best development? The house committee of some of our boards have, after a study of conditions, provided a greater variety of food and more milk for the children in their care. This is a point that might to advantage be considered by other boards of managers. — Several boards of managers have felt the need of more thorough visitations of families. Occasionally one or two of the managers have successfully carried this work for their nursery. It is seldom satisfactory to leave all of this work to the superintendent, however capable, or to depend upon the casual help of other organizations. A few nurseries have a paid worker for the outside duties who gives all her time to visiting nursery families and caring for the sick in the neighborhood. Others are employing the investigator who is connected with the office of our Association and find this help of the greatest assistance. This investigator is on call for any nursery that may need her services for regular days each week, or by the hour for a special case."

The Cleveland Day Nursery and Free Kindergarten Association considers their most interesting undertaking of the year a two weeks vacation in the country which they

gave to forty of the most undernourished children between the ages of two and six. Goodrich House Settlement loaned them their camp, and the children were given two rest periods a day and intensive feeding. Only two children failed to gain at all in weight, and in some cases the gains were most surprising, being five pounds, eight pounds, and even in one case, twelve pounds. This experiment will result in the establishment of a summer camp for children which they hope to open in a small way by next summer, and to increase in capacity and efficiency as time goes on.

The Director of the Springfield Visiting Nurse Association, Miss Florence M. Caldwell writes "probably our most significant piece of work during the year is the development of infant welfare work into the field of the pre-school child. Only three months ago we definitely started clinics for these children, although we have always given them incidental attention. Thus our child welfare program is complete from the pregnant mother to the child in school."

The Infant Welfare Society of Chicago reports that "because of the pressing need of saving the lives of children in the period in which there was the greatest waste of life —namely, the period covered by their first twelve months of existence—little or no attention has been paid to the child of pre-school age. When we begin to think of the three hundred thousand children in the United States who die before they reach the age of one year, we do, somehow lose sight of the fact that another one hundred and fifty thousand die before they reach the age of five years. It has taken an unreasonable length of time to carry this program over into the run-about-years." Miss Place continues:

"With the demand for this work came the demand for workers, and the question at once arose as to just who should carry such a program. Because we know what specialization has meant to the infant welfare problem of this city, we were anxious to secure the help of people who were best fitted to work into this new program, and have brought into our staff family six dietitians, who are specializing on the food problems of this two to six group. That they have been avid for the social training which the work demanded has been made manifest by their ever-increasing interest in the work and the success which has met their efforts.

Programs for infant welfare and school child work have been so standardized that there are milestones for our direction and success, but this most neglected group,—this two to six child,—had, until recently, no standards set up toward which we might work. The crux of the situation is the holding over of the mother's interest and attention at a time when it is being insistently diverted to a younger child.

We do so want to work out our program that we can teach mothers how to share their attention with all the needy ones, rather than with the tiniest and newest."

The Health Service of the New York County chapter of the American Red Cross, writes of a demonstration of work which began last May, with pre-school age children "The Red Cross in cooperation with the Health Department, the Department of Education, and Teacher's College, at the request of Dr. Ira S. Wile, and the Education Committee of the Civic Club, undertook to make twelve hundred children of pre-school age physically fit to enter school in September. During June the Health Department physicians in four schools in the East Harlem Health Center District and in four schools in the Henry Street District examined about six hundred children in each district, recommending what physical defects should be corrected. Nearly all of these children were also given mental tests by psychologists from Teacher's College. Up to July 1st over five hundred of these children had also been given dental hygiene treatment by the American Red Cross. In the East Harlem Section a follow-up nurse was engaged by the Red Cross and she is devoting her time to arranging for the removal of tonsils, adenoids and other physical defects. The Committee in charge considers this a very interesting and valuable demonstration, particularly in the way in which several agencies can work together for a common cause."

The Babies' Welfare Federation of New York City reports that a committee on the pre-school age child has adopted a standard record card, which has been published by the Federation, and which is now in use in clinics operated by ten different organizations. Copies of the cards will be sent on application to Miss Mary Arnold, 505 Pearl Street, New York City.

The Psycho-Clinical Service of Yale University, under the direction of Dr. Arnold Gesell, deals with exceptional mental and developmental conditions, particularly in children and youth, and has made special provisions for the developmental examination of children of pre-school age. The functions of the clinic are chiefly diagnostic and advisory. The findings and recommendations are given in consultation with parents and social workers, or when necessary, by typewritten report.

THE CARE OF OLDER CHILDREN

The Milwaukee Children's Hospital has a department of Occupational Therapy supported by the Junior League. "It is a wonderful institution for our small patients, as only those working with children can know what it means to furnish entertainment for them when activity is one of their normal attributes."

In the *Boston Baby Hygiene Association,* children in any one of the twenty-one conferences showing postural defects are referred to posture classes held in its stations in cooperation with the Boston School of Physical Education. Early detection of defects means easier correction and often prevention of permanent defects.

The Child Welfare Committee of Syracuse has operated a milk bar in the heart of the business section; conducted a Milk and Child Health Campaign during one week in May, in cooperation with the city and county health and welfare organizations, and maintained a summer camp for eight weeks which cared for one hundred and seventy-eight undernourished school children. They also made a survey and report on the sanitary aspects of milk production and distribution in Syracuse, and an investigation and report of conditions of ventilation in the Syracuse schools, including recommendations for improving existing conditions.

The Elizabeth McCormick Memorial Fund of Chicago, through Mrs. Ira Couch Wood, its director, reports: "The major activity of the Fund at the present time is intensive work for the undernourished child. Through its staff of eight full-time nutrition workers, three part-time nutrition workers and three volunteers, it organized and conducted thirty-five nutrition classes in and around Chicago during the year. The physical examinations of the children in these classes were made by the two medical directors for the Fund and five outside physicians. The Nutrition and Health Classes conducted by the Fund's workers are used as a medium for training leaders in this field. Twice a year the McCormick Fund, in conjunction with Dr. W. R. P. Emerson, conducts Institutes for the training of nutrition workers. It is also prepared to be of assistance to other cities in starting open air schools, health work in schools and nutrition classes, and will furnish, at cost price, the materials and equipment necessary. The Fund's specialist on Health Education in Schools is Miss Maud A. Brown, who was formerly director of health work in the schools of Kansas City. She may be placed at the service of any community wishing to develop the best methods of teaching health in the schools. Lecturers on the staff of the Fund may be secured to address meetings, and the Fund is prepared to make loans of wall charts, lantern slides, and moving picture reels on child welfare subjects. The Fund is being heartily congratulated upon the fact that Dr. Isaac A. Abt has recently been made one of its trustees. The Fund is planning to broaden its activities. The library is to be enlarged so that it may become a valuable reference library for child welfare workers, and efforts are being made to establish a Child Welfare Information Service during the coming year.

The Foreign Field

Latin America

The Bulletin of the Pan American Union for November, 1921, gives the following:

Colombia

Under the name of Cajas Escolares there was founded seven years ago in Bogota a charitable institution for the protection of poor children who attend the public schools and whose parents are not able to support them. This institution provides breakfast for all of these children and maintains in every school a restaurant where free meals are given daily. It also supplies the children with necessary clothing and is planning to open summer camps where children can have a vacation in the open.

Venezuela

The campaign for free milk stations for the babies of the poor has spread over many countries under the name of the "Gota de Leche." A new station for this civic work has lately been founded by the women of Maracaibo with the purpose of furnishing gratuitously properly prepared and sterilized milk for babies. The Gota de Leche will work in conjunction with the children's free clinic of Maracaibo.

The causes of infant mortality are being studied by the medical societies and the civil authorities of Venezuela, who will undertake to enforce legislation and spread information of benefit to the rising generation.

Chile

A new maternity ward is to be added at the public expense to the Hospital of St. Vincent de Paul. It will be completed this year, 102,900 pesos having been appropriated for its construction. It is expected that this ward will be one of the best equipped in South America.

A baby dispensary in Valparaiso, open two days a week, has been obliged to limit the daily number of babies admitted to fifty. Layettes are given and food provided at nominal cost. While this dispensary is part of the Presbyterian work in Valparaiso, it has been maintained since its foundation two years and a half ago, almost entirely by the generous gifts of Valparaiso residents, both Chilean and foreign.

Salvador

The municipality of San Salvador began the installation of its system of school lunch rooms as a feature of the centenary celebration. In addition to providing for these lunch rooms which will furnish school children with a properly balanced meal, the committee in charge hopes to collect sufficient funds to give school children excursions to the seaside where sickly and city-bred children may have an outing otherwise impossible for them.

Ecuador

A decree of June 6, 1921, creates a special fund, partly from a graduated inheritance tax, and partly from a small tax on imports and exports. About half of this fund is to be devoted to child welfare, especially milk stations, school lunches, day nurseries, orphanages, and children's hospitals. The other half is to be used for the construction and repair of school buildings throughout the Republic. The law is to be administered by the Federal Department of Public Instruction, with the assistance of local advisory boards.

Mexico

CHILDREN'S WEEK

In commemoration of the one hundredth anniversary of Mexican independence, the Department of Health instituted a Children's Week in Mexico City which was held September 11-17. More than ten thousand people attended. Celebrations were held in the public schools, with a view to interesting the children in hygiene, and there was a children's parade. One day was devoted to birth registration, and children whose births were registered on that day were given certificates signed by the president. Another day was visiting day for the general public at the various child welfare institutions of the city. The principal departments visited at the exposition were those where milk was hygienically sterilized, analyzed, and prepared for infant feeding. Some of the subjects treated were prenatal care; milk; infant mortality; children's diseases; care of children as to daiiy program, feeding, clothing, teeth and eyes; housing; and the rural child. Lectures on pertinent subjects were given both morning and afternoon.

NEW PLAYGROUND

The American Colony has presented to the City of Mexico as a centennial gift a playground for children, provided with modern apparatus and proper instructors. The formal opening took place on September 22. If this playground proves successful a permanent playground association may be developed.

SAFEGUARDING THE WORKING MOTHERS

In Mexico since 1919 the industrial code has declared that no woman employed either in domestic service or in a factory or workshop, may be permitted to work for a given period before and after childbirth. During this period the employer must pay her wages. This law is said to be generally observed. —*The American Labor Legislation Review, March,* 1921.

Cuba

VACCINATION FOR SCHOOL CHILDREN

The director of the sanitary department has ordered all head masters of schools throughout the island to vaccinate all school children except those who show satisfactory marks of recent vaccination.

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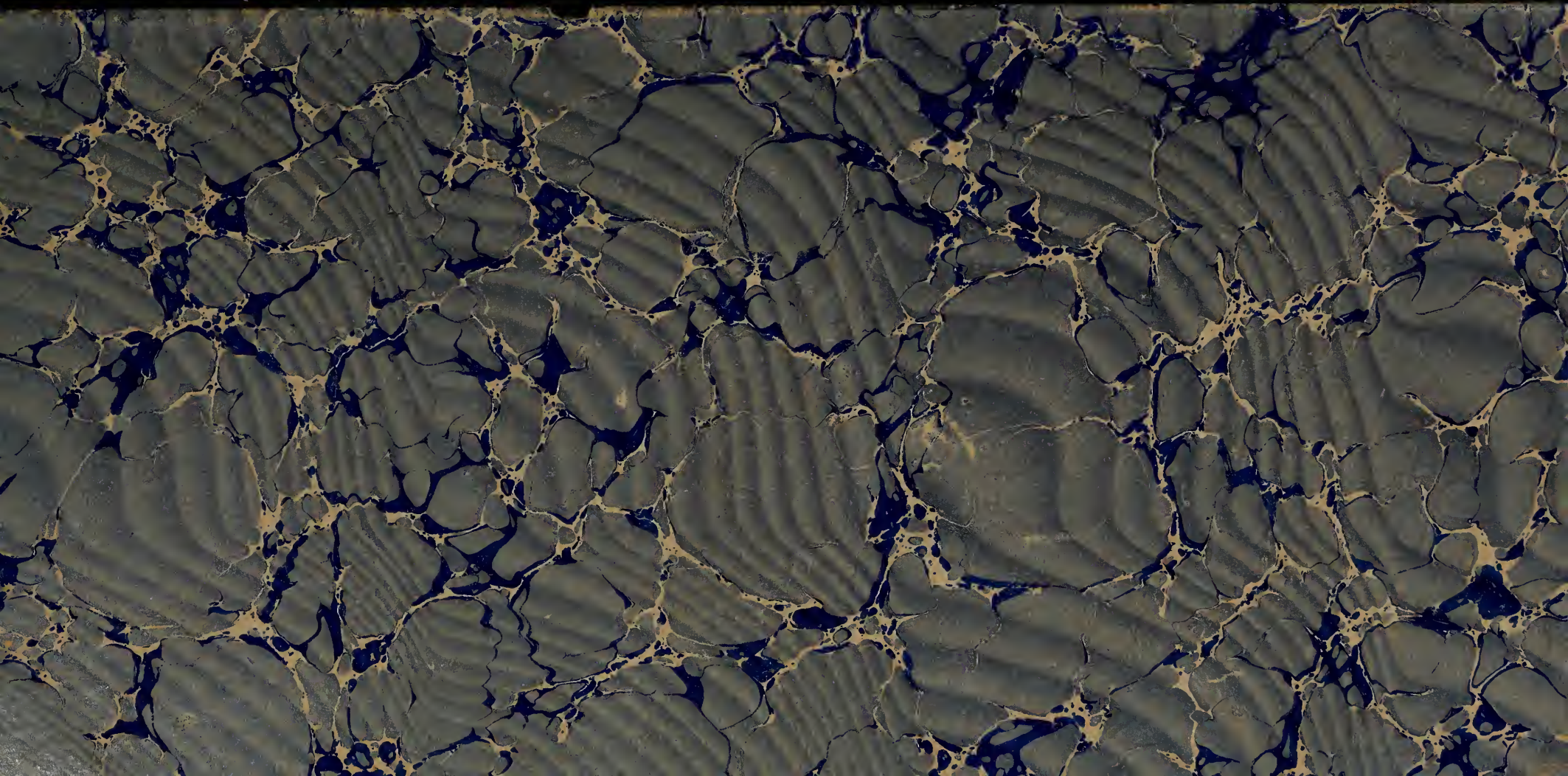
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